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Proem

If a grocery store, car dealer, hardware store, eBay, Amazon charges $100 for something, how much does it get paid? $100. If a healthcare provider (doctor, physical therapist, clinic, hospital) charges $100, how much does it get paid? It depends. It depends on the type of insurance, type of patient, service type. Type of insurance might be Medicare, Medicaid, private, none. Patient type means young, old, tall, short, full head of hair, bald, parent, grandparent, child. No, that would be too easy. It has nothing to do with the patient. It's about the relationship with the clinician - acute episode, continuous relationship, referred by another clinician, etc.). Specific types of service (medical, surgical, X-ray, lab, radiation therapy, preadmission testing, more than 200 types). All to figure out cost.

Cost? What does health care cost even mean? When politicians talk about costs, they're referring to federal and state spending on health care. Hospital administrators and physicians talk about the money they spend on the resources needed to care for patients. Business leaders mean the price of insurance or the amount they spend on their employees' health care insurance plans. Regular people think about out-of-pocket costs, the amount we spend beyond what insurance covers, plus costs of lost wages, childcare, transportation. You get the drift. Full disclosure – I will not be able to explain cost according to Medicare. I've been part of healthcare for almost 50 years, and I tried to study it further these past few days, and I cut myself off after 12 hours – I'm never going to understand it to explain to you. I have found no resource that I could give you to read to help you understand.

On the one hand, I apologize. On the other, that's the way it is. I'm smart and good at this, and it makes little sense to me. What sense does it make for cost to be so mysterious? Why even go down this road with you and devote an episode to Cost and Efficiency Measurement? Well, I'm on a National Quality Forum (NQF) Cost and Efficiency Measure Standing Committee as a patient-caregiver stakeholder. Everyone else on the committee represents health plans, clinician groups, measure developers, and statisticians. CMS (the Center for Medicare and Medicaid Services) engages NQF to manage cost and quality measures with the intent of providing consumers, you and me, with a 5-star rating for health plans, doctors, hospitals, and other providers of healthcare services. One star is terrible, five stars wonderful. I wanted to see how the sausage was made and ask questions that regular people might have. So, I closed my eyes, held my nose, felt the sweat dripping down my neck, and signed up for the Cost and Efficiency Standing Committee.

I met a fine fellow there, Matthew Pickering, Senior Director at NQF, who agreed to chat with us. You'll hear me use the word arcane. Arcane means *understood only by a few*. I will do my best to break in and explain where I can or let you know when I still don't understand. It's that thick. Buckle up.

Introducing Matthew Pickering 05:37

Health Hats: Matt. Welcome. Thanks for joining me today. I'm very excited about this conversation, and I've been looking forward to it for some time.

Matthew Pickering: Well, Danny, I very much appreciate your invitation, especially the consideration of my company, the National Quality Forum, and your involvement with some of the work that we do. I think this would be a great conversation, and I appreciate you thinking of me and as well as NQF for your podcast.

Health Hats: Great. So how do you introduce yourself?

Matthew Pickering: Oh, wow. Do you want the elevator speech, or do you want the long trajectory?

Health Hats: In between, more than the elevator speech?

Matthew Pickering: Matt Pickering, I serve as a Senior Director at the National Quality Forum. I'm a pharmacist by training. But I have ventured far away from the pharmacy realm. I haven't practiced in several years, and I worked primarily in the public health arena. I lead the team or a series of teams at NQF to convene stakeholders such as consumers, such as yourself, as well as other experts in the area and the field of the focus area, to evaluate measures that the government, Medicare Medicaid, use to assure that Medicare beneficiaries are getting the quality care that they need. I very much enjoy it. It's in this area of healthcare quality and performance measurements and trying to move the healthcare system from volume to value, which is a term that is often used. So, paying providers, hospitals, and physicians for the value they provide instead of the number of services or the volume they provide. I've

been doing that for a series of years. Before joining the National Quality Forum, I was at the Pharmacy Quality Alliance, a measure developer. So, they develop those quality measures, but ultimately it gets submitted to NQF to evaluate them to see if they are scientifically sound and evidence-based, et cetera for use within federal programs.

Value to whom? 07:48

Health Hats: All there are so many directions we could go with that. Let's start with when you say value. I'm hearing you say it's valued to consumers who are the recipients of care and service, but you measure clinicians and provider organizations, is that correct?

Matthew Pickering: That's correct. These measures look at these accountable providers, such as physicians or health systems or even health plans primarily for the Medicare population.

Health Hats: And of the Medicare population, is that straight Medicare and Medicare Advantage or just straight Medicare?

Matthew Pickering: It's both. It could either be Medicare Advantage or the fee for service. The term that we use fee-for-service Medicare, which is your traditional type.

Health Hats: Okay, so we met because I'm a patient caregiver stakeholder on the Cost and Efficiency Standing Committee. And my understanding is that we are not quite at the tail end, but we're near the tail end of the measure review process. And so, either existing measures are periodically reviewed, or new measures are reviewed. And we have a set of criteria that we look at, and we score the measures as the developers present them. And I confess that when I first started, I had no understanding of what my role was. So, I convened a group of people who were measured developers and researchers I had worked with at other technical expert panels to help me look over the material and understand the 60 or whatever pages of material for each measure. One of the things they taught me or encouraged me is to not worry about the statistic-ese and to look at it through my eyes and use my own language. One of the things that I appreciate working with you as the senior representative from NQF was that I felt respected by you. I felt what I was saying was valued and that you spent what I thought was a considerable amount of time interpreting what I was saying in the language of the group, and I appreciate that. And as I've gotten more mature in my role, now that I've been through three different cycles, I understand the criteria better. So, I feel like you've taken to this; you've bought into patient and caregivers being involved, you've drunk the Kool-Aid, and you're behind it. What was your trajectory like? I'm assuming that you weren't born this way, then you learned about it and advocated for it at some point. So how did that happen?

Moving from volume to value 11:37

Matthew Pickering: That's a great question. Danny, I will say that I'm starting to go back to the comment you mentioned about value. This changing healthcare environment that we find ourselves in

and continue to find ourselves in. So, we're moving away from paying providers, whether they be clinicians, hospitals, health plans, for the volume of services they're providing and moving to the value of services they're providing that value is measured or partly measured through these quality measures. Partially, we are doing this because, yes, we want to ensure that there's good quality care being provided. Part of that value equation is also looking at the cost of services, the number of dollars spent. So, you've got this value equals quality over cost type of equation to put it in a very simplistic form.

Health Hats: *Value=Quality/cost simply means getting the biggest bang for your buck in healthcare. However, nothing in healthcare is simple, especially when there's so much money involved. CMS estimates that in 2019 healthcare "costs' reached $3.8 trillion or more than $11,000 per person. As a share of the nation's Gross Domestic Product, health spending accounted for just under 20 percent. There are a lot of people and companies after a slice of that monster pie.*

Quality and cost measures help choose plans and providers 13:41

Matthew Pickering: So those measures, the quality measures are trying to identify that quality care and that cost of care and together putting together value. But ultimately, it's also to inform the consumer of the quality of care being provided to them, whether it be physicians or hospitals, et cetera. The goal is to improve quality and inform consumers, patients, and caregivers patient advocates of the quality of care being delivered. Programs that these measures are used to evaluate providers should be made transparent and are made transparent to Medicare beneficiaries in particular. So medicare.gov is a website that many beneficiaries of Medicare go on and decide what services or what types of plans they'd like to choose depending on drug benefits, what conditions they have, who covers it, et cetera. So, it's left to consumer choice, and through these types of quality measures in these value-based shifts in healthcare, the quality measures are communicating the quality of care that's being delivered to those beneficiaries. And so, beneficiaries have decisions to make. They can make informed healthcare decisions based on how well providers perform on these quality measures.

Consumer seats at the table 15:06

Matthew Pickering: So, it almost makes sense that if you're trying to inform consumers about the quality of care that's being provided, those same individuals, those beneficiaries, and patient advocates should be at the table when you're evaluating these measures, to begin with. And bringing that patient voice into the evaluation process is not a new approach, and it's something that is still evolving. Danny, as being involved with the work that we do, we're still evolving how to meaningfully engage patients and patient representatives in this process. But ultimately, if the end goal is to inform the consumer on the quality of care that's being provided, we should bring them into the process of evaluating these measures to say that this is meaningful to me as a patient. This is meaningful to me as a caregiver and within these standing committees, Danny. I love how you remember the term you used. What did you say about your term?

Health Hats: Statistic-ese

Matthew Pickering: Statistic-ese. That's great. And you mentioned that because even in these bodies that we convene to evaluate these measures, we're trying to bring in more patient representation into that. There are various levels of expertise that are around the table. There's clinical expertise, there's research expertise, but we also need lived experts. We need that voice that doesn't always get captured in these evaluations of the lived experiences. And that's the expertise that we also need to consider in the evaluation of these measures. And that's what we've been trying to do. And I would say, Danny, I think you do a phenomenal job asking those types of questions based on what this means to me as the consumer? What does it mean to me as the patient or caregiver or an advocate for other types of patients with similar conditions or other conditions? What does it mean? Those types of questions are very meaningful because they also suggest that there needs to be an additional consideration here. How has this translated to the patient and consumer?

Cost, is it real? 17:09

Health Hats: There's a couple of things in what you said. I sit on this Cost and Efficiency Standing Committee, and the measures that come up are the overall cost of care per beneficiary or for a particular diagnosis. And there's all this conversation about what's included and excluded, but all of it seems like it's based on claims data. I just so struggle with that because I feel that in the American system of health care, it feels like cost doesn't represent anything real to me. I'm like, is that what people charge? Is it what actually costs them? Is it what the beneficiary pays? Is it what the plan pays? And it doesn't include cost that feels important to patients and caregivers like the cost of lost wages, for caregivers, the cost of getting sick themselves. Or if we're thinking about clinicians, the cost of burnout. And it's so it seems like this idea of cost is such a small slice. Okay, so I asked those kinds of questions, and then I think, okay, this is a question that needed to be asked way sooner, or it's more of a policy question than a measurement question. Can you talk a little bit about where would those kinds of questions, where would they see the light of day?

Matthew Pickering: Yeah. Yeah. It's a great question, Danny, and you're right. We use claims data currently to develop these types of measures, specifically when you're in this context of cost. The cost measures are relatively new to the system. And when I say to the system, in this area of quality, these cost measures are a completely different animal, if you will, that are looking at the cost of services, right? Healthcare resource use, primarily from the perspective of holding a health system accountable for the number of dollars they're spending on a particular condition or a service or a time window around some whether it be a discharged from a hospital, how many dollars are being spent outside of that event. And these measures are new and using data sources that we know are standardized and valid like claims. These other aspects of out-of-pocket costs, indirect costs, whether it be from taking time off work or whether you're talking about the job loss and things of that nature, there are those elements of cost that could be considered and factored into quality measures. These are factors that can impact the quality of care delivered. And we must think about adjusting or accounting for those types of costs factors that potentially impact the quality of care provided. There's also maybe new evolution of cost measures that could come down the pipeline once there's more data connectivity and sharing of potential data to learn more about out-of-pocket costs and more transparency with that. So that we're able to monitor how much is it impacting the patient and their out-of-pocket cost. We're still a little way

away from getting into those types of standardized measurements. Because administrative claims are the means that providers and health systems can communicate with services that are provided in a standardized way. But to get to that more granular level of how does this impact out-of-pocket cost for a patient, or what does this mean for other types of indirect costs for time off work or time for childcare? Those are significant factors when you're talking about money out of the patient's pocket, but there's not an excellent way to capture a lot of those data elements in a standardized way. It has been discussed by government agencies, by other types of institutions like the Patient-Centered Outcomes Research Institute, PCORI which I think, Danny, you're very much involved with. How do you start to capture these data elements? How do you then capture them in a standardized way that you can research them?

Health Hats: *You know the story of the person looking for their keys under the streetlight when they lost them in a dark alley. "But that's where the light is." Unfortunately, I fear that we've put effort into standardizing the data under the streetlight rather than in the dark alley. How can consumers like you and me trust cost measures when they seem to miss the point?*

Measures inform and inspire, don't they? 22:27

Health Hats: Okay. If we assume these measures are suitable, practical, essential measures. The next part that I focus on is how do these measures either inform or inspire? So, the whole purpose of measurement is that it's a way to keep our fingers on the pulse of something. I would assume that there is variation in results and that somehow, we think that something is good and something is less good. So, it's cost and efficiency. How can we learn from what is more efficient and what is less efficient? And then that helps. Then if we can share what we've learned, that helps more generally for whatever to be more efficient. But I don't get a sense when I'm there. I realized that what I'm saying was ill-formed. But the point is, and it is a criterion. A criterion is that these are used. These measure results are used to inform change. But I don't know that I see evidence of that in our discussions. Yeah. Can you speak to that?

Matthew Pickering: I can. Danny, you asked excellent questions like this within the standing committee proceedings. The cost and efficiency standing committee evaluates cost measures to assess those measures based on a standard set of criteria that NQF owns and operates and maintains those criteria. And ultimately, it's to inform the quality of care. Inspiring patients to go to these medicare.gov websites or the website and look for health systems or health plans or even nursing homes. All these data are in there and displayed for consumer decision-making and choice on what provider they would like to go to for their services based on what has been displayed on medicare.gov because those quality measures used in those programs are evaluating those providers.

Cost is different. Smoke and mirrors? 25:23

Matthew Pickering: With costs, it's a little bit different because it's relatively new. These measures have been developed from recent government legislation. These measures will now be used within these quality improvement programs to assess the number of dollars that these providers are spending for the

care they provide. So, this is like a resource use type of situation. You have a lot more resources that you're using. There are a lot more procedures that you're using. There are a lot more dollars attached to that. But how does a provider in Cleveland compare to a provider out in San Francisco with this same type of service? Is one provider spending more money or not. And so, these measures are intended to monitor that, and they're trying to display, ultimately, if this provider is spending more money or not, or less money compared to a national average. What does this mean to the consumer? The consumer could say this provider performs well on this quality indicator of keeping me out of the hospital. I know that this provider keeps patients just like me out of the hospital, more so than the hospital over here. But it's also with this cost element. Eventually, the cost element will get worked into these types of transparent ratings that beneficiaries can go in and look for and say, not only is the quality of care improving here.

Not only am I seeing on this medicare.gov that this provider is keeping me out of the hospital after 30 days, but they're also saving some money. It's just to help inform the decision that if provider A is doing high quality but less cost than provider B, a patient has a decision to make. Maybe provider B is closer, right? Maybe hospital B is closer to the patient, the hospital. But hospital B has a higher cost. So, it just depends on what works better for the patient. The patient wants to travel further to see provider A because of fewer costs, but still performance high quality. That's ultimately where we're trying to get. And that's this efficiency realm, right? How efficient is the provider at spending less money but giving the same high-quality care?

Do consumers use this cost and quality information? 27:45

Health Hats: I think a couple of things in that the first one is, do consumers look at this stuff?

Matthew Pickering: That's a great question.

Health Hats: Yeah. Yeah. I guess I'm embarrassed to say, but I don't know that I've ever looked at it, and here I am eyeball deep in it. I guess I better do that, so I know what I'm talking about. But I don't know that. Yeah. But what's your experience like? What kind of feedback do you get? The only time people are going to look at that is maybe it's elective. There's nobody that's having something emergent is going to a website before they get their broken limb fixed. Yeah,

Matthew Pickering: it's a great question, Danny. And you're right. There may not be those instances where somebody who broke their leg right is then going to medicare.gov quickly and trying to identify is this hospital. It's based on a five-star system, right? Five stars being the highest, just like Yelp. Are they going in and looking to say before I call the ambulance 911, let me just check out to see what hospital I want to go to. Maybe those instances do happen. Maybe not right. I do know that there is some impact to this. Consumers do pay attention to this, and it may not be across the board. There are different domains that the government has to evaluate health care providers. There are domains for individual clinicians. There are domains for hospitals. When I say domains, these are areas where quality improvement programs and measures are being used to evaluate hospitals, nursing homes, physicians,

health plans. In data, we see that for something like health plans, where your Medicare Advantage and your Medicare Part D the drug benefit, they have measures that evaluate them. And those measures could be things around medication adherence. We think about Part D making sure patients are adherent to certain medications that we know if you're adherent, it leads to beneficial outcomes. There are other measures around appropriate diabetes care within these health plan quality improvement programs or evaluation programs.

Who would want to sit on this cost committee? 30:51

Health Hats: One of the reasons I'm on the Cost and Efficiency Standing Committee is because I thought, who would ever want to sit on this committee?

Matthew Pickering: That's right. Who would ever want to lead that committee? I don't know who would do that crazy job.

Health Hats: I can understand advocates and patients and caregivers wanting to sit on a diabetes committee or a stroke committee or whatever. I selected this one because I thought this is about as arcane as I could think of. It seemed like there would be no competition. One of my goals as in my role as an activist and, be in this health hats, wearing all these different hats is to open seats for other people and to encourage other people to step in, to even step in, in something that isn't yet well-developed or is arcane. But that there is a role, and it's worth understanding, and it's worth participating. I think it contributes to the critical mass of iterative change in the use of measures and measure development. So how do you think I can best inspire other people to participate in any of the NQF processes, specifically the cost and efficiency processes. And when I think about that, I think about who's the audience, what's the message, You know what I want to have come out of this, your and my conversation, is I want to end with I would hit a home run if one person who listened to this got in touch with you and said, I want to participate. That would be amazing. So then, to me, it's a tactical question. Okay. Who's the audience, and what's the message. What do you think about that?

Matthew Pickering: So just speak to that, Danny. You are involved on a very technical standing committee, and I am overly impressed by how you are engaged with the group. And as you have mentioned, yes, the first time around, it's very foreign, and it's all new information. I love how you've connected with some of your colleagues offline about approaching your involvement, which I think was fantastic. But how you are inspiring is through what you're doing now. I think being involved, putting your foot in the door, and then having a seat at the table. And then learning about the process and then

sharing that through avenues like this, I think, provides that inspiration. I believe you also have learned tremendous amount about our work and how this ultimately will impact the healthcare system at some point and have asked relevant questions. Thoughtful question to developers and those entities that use these measures such as CMS, Medicare, and Medicaid Services, who are on those calls, who you ask those questions to them. So even the implementers of these measures hear the patient voice now, and they've very much value that. It is something that CMS, the Centers for Medicare and Medicaid Services, does a lot of work with us, and implements our measures. They have a national priority to try to incorporate the patient and community voice within this work. They are very responsive to what the patients have to say within these committees and even outside of costs, which, again, you are on, and it's a very technical committee.

Health Hats: That's better than arcane.

Participating 34:33

Matthew Pickering: We have other standing committees across various focuses. So, we have other standing committees look at surgery, cardiovascular disease, kidney care, so renal functioning. We have others that look at readmission rates. We have others that look at geriatrics and palliative care. These are other areas, and there are many others that we have measures that are submitted to. And we're always looking to seat patients and patient representatives or community representatives on these committees. And I'll just say that we still have opportunities for those from the patient community to participate in other NQF activities beyond those committees. We have a Patient Caregiver Advisory Committee, which is not so much evaluating measures, but it's trying to inform us how to engage patients better? How do we bring patients into this work better? And so that is also an opportunity that we seek to have the patient voices within that group; outside of that, there are other areas that we look to have patients involved in through various other works or our one-off projects that we do. And, within what we have, our measures application partnership is another NQF-convened group. All of this is available online, and we recruit every year, all the time. And patients and those from the patient community can go online and apply when we call for nominations to be seated on these committees.

Danny, I think this has been fantastic

Health Hats: Thank you very much. I appreciate you joining us.

Matthew Pickering: Danny, thank you so much. And I must say I'm looking forward to hearing the jazz music you'll be putting on it. I don't know if you're going to put this in your recording or not, but to the listeners, I've just loved your production on your podcast? I love the jazz music transitions. There are fantastic.

Health Hats: Oh, good. Joey van Leeuwen that's who's doing it. Yeah. That's great. Thank you. All right, thank you, sir. I'm sure we'll be talking soon.

Reflection 36:40

What do we do at these meetings besides flounder if we are unlikely to ever understand cost according to Medicare or other insurers? What do I care about? What questions do I ask at these meetings? I care that measures about cost and resources used in healthcare explicitly state and truly reflect something relevant to patients, caregivers, and direct care clinicians, like doctors and nurses. That measure results inform improvement at the local and community level. And that improvement in care and service has already been demonstrated, and there is the likelihood for continued improvement. The approach I take is to read and understand as much as I can before these hours-long meetings. I come up with questions in my language and find places to ask them even if they don't seem to fit anywhere.
For example, I care about health equity. How do these measures inform our understanding of inequities? I noticed that the measure developers (companies paid to come up with and test measures) reported that each of the social risk factors was statistically significant in the risk adjustment model. In English, some data points reflect zip code, housing, a social disparities scale. I can tell you more. However, the developer did not include them in the overall model, concluding that adding them, individually or together, did not substantially improve overall model fit. The developer reported that including social risk factors in the risk-adjustment model had minimal impact on measure scores. I thought, "this is nuts." How can it not matter? I brought it up. It's the developers' job to explain, so I understand. I didn't. My colleagues on the Panel felt I had a point and continued the discussion statistics-ese, which I didn't understand. But the measure was not approved. Unheard of but empowering for me. My last point is that I don't understand how these measures can ever smell like transparency when I can't explain to you what cost even means.

Still, all is not lost. People with lived experience are patients or caregivers and people with many skills, perspectives, and expertise. Suppose you can step into an intimidating situation, feel your vulnerability, and ask the "dumb" questions. In that case, I encourage you to sign up as a patient caregiver rep and jump right in. NQF pays a stipend for your time, the staff is supportive, and other patient-caregiver reps will welcome you with open arms. We won't move from muddy to transparent without you.