

Methodology One Pager

Background and Context

After decades of fee-for-service (FFS) reimbursement in the United States, health plans, government payers, hospitals systems, and physician groups have begun adopting new models of health care financing. The Centers for Medicare and Medicaid Services (CMS) have accelerated this shift by releasing data and incentivizing both payers and practitioners to deliver health care in a way that emphasizes value over volume.

CMS has stated that low-value services comprise the single greatest weakness of the fee-for-service system. Like academics, researchers, payer and physician industry groups, and the popular press, CMS defines success in pay-for-value arrangements by the degree of reduction of low-value care. Low-value care is defined as care that costs more but fails to produce better outcome¹. According to the Institute of Medicine, thirty cents of every dollar spent in health care goes to unnecessary services that result from unexplained variation in care.²

Open Data & Open Methods

To date, CMS has released four full years of claims data for Medicare FFS Parts A, B and D. These files provide procedures and prescriptions billed by each individually named practitioner. Additionally, these files contain data including panel disease burden and prevalence, utilization, health behaviors, and socio-demographic indicators. The releases also show patient flows and shared transactions between practitioners and facilities, and additional information.

RowdMap seeks to identify practice pattern variation as it relates to a practitioner's ability to manage populations and limit low-value care. Our organization uses CMS public data sets described above to identify, to quantify and to attempt to reduce low-value care. The public data we use are benchmarked according to decades of academic research. This methodology comes from the Dartmouth Atlas for Health Care; the ABIM Foundation and its Choosing Wisely Initiative, which represents over seventy specialty societies; the Institute of Medicine; and the Committee on the Learning Health Care System in America and its "Best Care at Lower Cost."

1. www.medpac.gov
2. <https://www.nap.edu/read/12750/chapter/1#v>



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RowdMap Risk Readiness® Scores

RowdMap's approach is aimed at identifying whole-system care patterns that are aligned with high value. Identifying high value providers and pathways are essential for population health risk management and reducing low value care. Provider efficiency scores combine clinical quality and medical economic metrics to measure value. Scores are mapped to the way providers make clinical decisions and show how they compare to their peers.

1. Data

RowdMap starts with public data from CMS (described above) and builds specialty specific clinical ontologies that classify provider visit, procedure, and pharmacy claims into clinically meaningful categories.

2. Peers

RowdMap compares practitioners that practice in similar ways within the same geography. We develop peer cohorts based on actual Medicare Part A, B, and D claims activity. For example, the practice patterns of an orthopedic surgeon who completes mostly shoulder surgeries in Louisville, KY will be compared to other orthopedic surgeons who complete mostly shoulder surgeries in the same geographic area. For most specialties, the Hospital Referral Region (as defined by *The Dartmouth Atlas of Health Care*) serves as the geographic area of comparison.

3. Measures

RowdMap's measures are designed to capture the full spectrum of care delivered across inpatient, outpatient and pharmacy settings as well as referral activities. RowdMap's measures are created to mimic clinical reasoning and decision-making. Measures are designed to measure clinical quality (i.e., what is the best outcome) and medical economics (i.e., what is the best outcome for the dollar spent). The measures are risk adjusted based on HCC risk scores, TCRRV, and by specialty peer cohorts.

Summary

RowdMap Risk Readiness® scores seek to identify the practitioners who are more likely to practice in ways that effectively manage a population's health and who are likely to succeed in medical economic models that prioritize value over volume. This approach also provides public visibility using third-party data from CMS. From it, we can describe how a practitioner practices compared to her peers within a geography and can identify opportunities to succeed in new economic models as the focus of the delivery system moves from volume to value.

