Aligning Forces for Quality | Improving Health & Health Care in Communities Across America

Robert Wood Johnson Foundation

PRIMER/BRIEF

Public Reporting of Cost & Resource Use Measures

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Introduction

The cost of medical care in the United States has been rising steadily over the last several decades, far outstripping the rate of inflation. While much of this cost has produced innovations that extend life and improve human functioning, there is substantial evidence that more efficient use of resources could produce significant savings without adversely affecting the quality of care. In addition, the health reform law and other payment innovations are expected to reshape health care delivery by aligning provider, purchaser, and consumer incentives to encourage more efficient, evidence-based care. Public reporting of cost and use information can help payers (including health plans and employers), providers (including hospitals and clinicians), and consumers (including patients and their families) navigate this changing environment.

While demand for cost and resource use information among payers, providers, and consumers appears to be increasing, its value may not be fully realized by some—or all—of these stakeholder groups in each community.

I. Payers

Together, businesses, patients, and insurers spend nearly $700 billion a year on services that may not improve people's health. In 2003, poor-quality care cost businesses between $1,900 and $2,250 per employee annually.[1] Public reporting of cost and resource use information can encourage more efficient use of health care dollars by allowing payers to:

About Aligning Forces for Quality

Aligning Forces for Quality (AF4Q) is the Robert Wood Johnson Foundation's signature effort to lift the overall quality of health care in targeted communities, as well as reduce racial and ethnic disparities and provide real models for national reform. The Foundation's commitment to improve health care in 16 AF4Q communities is the largest effort of its kind ever undertaken by a U.S. philanthropy. AF4Q asks the people who get care, give care and pay for care to work together to improve the quality and value of care delivered locally. The Center for Health Care Quality in the Department of Health Policy at George Washington University School of Public Health and Health Services serves as the national program office. Learn more about AF4Q at www.forces4quality.org. Learn more about RWJF's efforts to improve quality and equality of care at www.rwjf.org/qualityequality/af4q/.

About the Author

American Institutes for Research (AIR) provides technical assistance for the Robert Wood Johnson Foundation's *Aligning Forces for Quality* initiative. AIR is working with Aligning Forces communities to support effective public reporting of cost and resource use information that encourages higher-quality health care at lower cost and authored this publication.

[1] Midwest Business Group on Health in collaboration with Juran Institute, Inc. and The Severyn Group, Inc., Reducing the Costs of Poor-Quality Health Care Through Responsible Purchasing Leadership, 2003, http://www.mbgh.org/templates/UserFiles/Files/COPQ/copq%202nd%20printing.pdf.

- **Compare costs and resource use across markets to inform purchaser contracting decisions.** Publicly reporting measures like Relative Resource Use (RRU) measures, which combine cost and quality, can help purchasers assess and select plans that deliver the best quality care for their money.[2]

- **Compare costs and resource use across providers in a market to inform plan and purchaser network decisions.** The Delaware Valley Health Care Coalition, a group of union funds representing plumbers, teachers and municipal workers, used publicly reported hospital discharge data from the Pennsylvania Health Care Cost Containment Council to inform the development of a high-performing provider network. Payers can use these networks in conjunction with incentives to encourage wiser use of health care resources.

- **Identify services with wide variation in utilization as potential targets for standardization based on clinical guidelines.** A recent report from The Dartmouth Atlas Project and the Foundation for Informed Medical Decision-making found that men over 65 with early-stage prostate cancer are 12 times more likely to have their prostate removed surgically if they live in San Luis Obispo, California than if they live in Albany, Georgia. Publicly reporting cost and efficiency measures enables payers to easily see where these variations occur and help standardize delivery of services based on clinical norms.

- **Identify opportunities to provide better care at lower cost.** A number of studies have identified hospital re-admissions as numerous, costly, and potentially preventable. Efforts to ensure that patients have adequate information, clinical follow-up, and support services at the time of discharge can improve quality and reduce costs simultaneously (payment models based on shared savings or bundled payments for an episode of care may help align hospital incentives to encourage these practices). Public reports can serve as the catalyst and help inform quality improvement programs that accomplish these goals.

- **Assess trends to identify areas of rapidly-increasing resource use and assess appropriateness.** Over the last several years, there has been a dramatic increase in utilization of imaging (e.g., CT, PET, and MRI), which has garnered attention from the Medicare Payment Advisory Commission and spurred efforts among payers to create new initiatives to address the associated costs. Public reporting of resource use can help payers isolate and act on trends quickly, making it easier to identify instances of inappropriate use and drive down costs.

- **Promote competition among providers on both cost and quality to improve the overall value of health care.** Studies have found that reporting comparative information on quality in a way that captures the attention of consumers will prompt health care providers to improve their quality in order to preserve their reputations.[3] In a similar way, public reporting of cost and efficiency information should focus providers' attention on, and result in, wiser resource use.

Project Boost: Helping Payers Increase Efficiency

Project Boost is a national initiative led by the Society of Hospital Medicine in collaboration with a multidisciplinary group of stakeholders. It aims to reduce hospital readmission rates by improving the transition of patients from hospital to home. According to the website, "early data from six sites, which implemented Project BOOST, reveals a reduction in their 30 day readmission rates from 14.2 percent before BOOST to 11.2 percent after implementation; also, **producing a 21 percent reduction in 30 day all-cause readmission rates**. Pilot sites indicate that BOOST tools are well received by health care teams and patients as it improved communication and collaboration across functions within the hospital and outpatient physicians. Patients reported a very positive response to what they perceive with an increased level of service and medical attention."

[2] The National Committee on Quality Assurance (NCQA) has developed Relative Resource Use (RRU) measures for five chronic conditions: diabetes, asthma, cardiovascular disease, COPD, and hypertension. Additional information on NCQA's RRU measures can be found at: http://www.ncqa.org/tabid/1231/Default.aspx.

[3] Hibbard JH, Stockard J, Tusler M. Hospital performance reports: Impact on quality, market share, and reputation. *Health Affairs (Millwood)* 2005 July-August: 24(4):1150-60.

II. Providers

By participating in the report development process, providers can help ensure the information about their practice's cost and resource use is credible and accurate. Public reports containing cost and resource use information can help providers:

- **Prepare for and benefit from participation in new delivery models and payment reform initiatives.** In addition to containing financial incentives for achieving cost savings and quality improvements, health reform efforts such as Patient-Centered Medical Homes (PCMHs) and Accountable Care Organizations (ACOs) will require clinicians to track and report on key cost and resource use measures.[4] Payers and purchasers will be relying on public reports to determine pay-outs resulting from these new initiatives.

California's Pay-for-Performance (P4P) Initiative: How Providers Can Benefit From New Payment Reform Initiatives

California's P4P initiative, led by the Integrated Healthcare Association, has started tying a number of resource use measures—including inpatient readmissions within 30 days, emergency department visits, and the generic prescribing rate—to financial incentives. The goal of this initiative is to give providers an incentive for helping to reduce the cost of care without compromising quality of care.

- **Identify and act on opportunities to increase the efficiency of care while maintaining or improving quality of care.** Websites that report cost and resource use information, such as www.CalHospitalCompare.org, provide comparative assessment data on a variety of measures, allowing providers to track and benchmark how well their practice is managing costs and resources. The information also allows providers to identify and focus on key areas where there is opportunity for improvement.
- **Demonstrate efficient use of resources.** As payers and patients turn their focus to selecting higher-value providers, information found in public reports—such as data on how well providers deliver high quality care while making efficient use of resources—can be used by providers to negotiate contracts with payers and attract new patients.

III. Consumers

To support health care reform initiatives, plans and purchasers will be directing consumers to comparative reports of quality and cost information. Consumers will be expected to play a more active, informed role in their health care choices. Public reports can help consumers:

- **Make better health care choices by considering cost and resource use when making decisions about plans, providers, and services.** Public reports of cost information, when linked with information on quality, can help consumers understand that variations in costs and resource use are not explained by differences in quality or patients' needs—that is, price is not a proxy for quality.[5] Additionally, public reports present an opportunity to educate consumers that more care is not always better, and that receiving inappropriate care (such as lower back imaging tests when they are unnecessary) can cause additional health problems that cost more to treat.[6]

[4] Health Affairs/Robert Wood Johnson Foundation Health Policy Brief, Accountable Care Organizations, July 2010, http://www.rwjf.org/healthpolicy/product.jsp?id=68929; Health Affairs/Robert Wood Johnson Foundation Health Policy Brief, Patient-Centered Medical Homes, September 2010, http://www.rwjf.org/healthpolicy/product.jsp?id=66449.
[5] The Dartmouth Atlas, The Dartmouth Institute for Health Policy and Clinical Practice Center for Health Policy Research, Health Care Spending, Quality, and Outcomes, February 2009, http://www.dartmouthatlas.org/downloads/reports/Spending_Brief_022709.pdf.
[6] Jacqueline Baras Shreibati, M.D., physician resident, Stanford University School of Medicine, Stanford, Calif.; Anders Cohen, M.D., chief, spine surgery and neurosurgery, Brooklyn Hospital Center, and assistant professor, neurosurgery, Weill Cornell Medical Center, New York City; April 2011, *Health Services Research.*

- **Shop for medical care when they have significant exposure to out-of-pocket expenses.** Public reporting of out-of-pocket costs can provide consumers—particularly those in high-deductible plans—with valuable comparative pricing information so they can choose where to get their medical care.[7] Public reporting on costs, such as that provided by the Consumer Reports' Best Buy Drugs website, can be helpful to consumers shopping for medical care.

- **Understand and navigate the coming changes in benefit design.** Benefit designs are emerging that move toward value-based principles, such as lower cost-sharing for more effective types of care. Consumers will be directed to public reports of cost and resource use information to provide them with information that is easy to understand, and that they can use to make choices that reflect the goals of value-based benefit design.

"In 2010 two Oregon public employee benefit boards implemented value-based insurance design programs for state workers."[8] The Oregon Public Employees' Benefit Board—a partner of Aligning Forces grantee the Oregon Health Care Quality Corporation—is one of these employers. "Employers have reported that the introduction of the plan design went smoothly. Employees understood the rationale and value of the design." Joan Kapowich, Administrator for the Oregon Educators and Public Employees Benefit Board, attributes this success to an effective communication strategy and providing employees with the tools to aid their decision making process. Since implementing the plan, Ms. Kapowich has heard from employees that they are more engaged with their health care.[9]

Oregon's Value-Based Benefits Initiative: Helping Consumers Navigate Changes in Benefit Design

The Oregon Health Leadership Council, a collaboration of health plans, hospitals and physicians, has created the Value-Based Benefits Initiative. This Initiative features three tiers of services:

Tier 1: No or low out-of-pocket costs for "Tier 1" services, defined as services required for six chronic conditions and proven preventive services;

Tier 2: Standard deductible and coinsurance for "Tier 2" services, defined as the majority of services covered; and

Tier 3: Substantial cost-sharing for "Tier 3" services, defined as those "nationally recognized as overused and driven by provider preference or supply rather than evidence-based need."

[7] Examples of consumers with high out-of-pocket costs include: those with high-deductible health plans who are paying for services in full before meeting their deductibles; those with substantial coinsurance who are responsible for 20-50% of the cost of services; and those who have limited or no insurance coverage in one or more areas of health care (commonly pharmacy benefits, maternity care, vision care and/or dental care).
[8] Kapowich, J. Oregon's Test of Value-Based Insurance Design in Coverage for State Workers. *Health Affairs* 2010 November: 29(11):3028-32.
[9] Oregon Health Leadership Council Progress Report, p. 8 (January 2011), http://www.orhealthleadershipcouncil.org/wp-content/uploads/2011/01/Progress-Report-January-2011FINAL.pdf.