



*"We Understand Health Care"*

## **Implementing Value Based Purchasing:**

*Policy Options, Practical Refinements*

**April, 2007**

This White Paper was prepared in response to a request by the Centers for Medicare and Medicaid Services (CMS) for input into their Options Paper for Medicare Hospital Value-Based Purchasing. Portions of this paper were presented orally by John D. Shaw, Next Wave's President at the Listening Session held on April 12, 2007 at CMS offices in Baltimore.

## **Implementing Value Based Purchasing: Policy Options, Practical Refinements Executive Summary and Recommendations**

Next Wave formally acknowledges the excellent work performed by the VBP team in preparing their Options Paper on Value Based Purchasing presented at the April 12, 2007 Listening Session. The changes we saw between the January and April sessions are striking. What resulted is a very understandable system. Summary Recommendations follow, discussion is in the full white paper.

Our comments focus on specific areas where input was requested and provide recommendations for refinements. We believe our input can help the team tie the details together into a structure that is both understandable to the general public and acceptable to Congress for implementation. Our recommendations are organized in each of the four major design areas:

1. Incentive Structure (Timing, Amounts, and Mechanisms for VBP payments)
2. Measures of Value (Quality, Patient Experience, Efficiency)
3. Data Infrastructure & Validation (How data for the measures are collected and audited)
4. Public Reporting (Transparency for all Stakeholders – in a useful format)

### **1. Incentive Structure (Timing, Amounts, and Mechanisms for VBP payments)**

We support the basic incentive payment design to reward past performance (“B.” below.) Our suggestions for refinement can best be visualized in relation to the overall Value Based Purchasing Model. We suggest refinements in both the data infrastructure (“A.” below) and how “Residual” funds are used (“C.” below.) We also recommend specific technical refinements in each area.

#### **A. Data: Build & Maintain Infrastructure**

#### **B. Reward Past Performance**

#### **C. Option 3: Invest Residual in Future**

<b>Pay for Reporting</b>	<b>Pay for Attainment</b>	<b>Pay to Share</b>
<b>Pay for Reporting</b>	<b>Pay for Improvement</b>	<b>Pay to Test</b>
<b>Reimburse Cost Incurred</b>	<b>Incentive Payments</b>	<b>Reimburse Cost Incurred/ Recognition</b>

### **A. Specifically Recognize the Need and Costs to Build and Maintain the Data Infrastructure**

*We recommend that “Pay for Reporting” be continued – at fixed amounts representing estimated fixed costs of reporting the VBP measures (e.g. initially set at \$50,000 for facilities under 100 beds, \$100,000 for facilities from 100-199 beds, and \$200,000 for facilities 200 beds and over.)<sup>1</sup> This would:*

- *Address small hospital “fairness” concerns,*
- *Support collection of performance data from ALL hospitals for policy analysis and transparency to consumers*
- *Allow an easier to understand linear “exchange rate” to translate performance*

*score into payment*

### **B. Rewarding Past Performance for both Achievement and Improvement**

We agree with the basic structure of the proposal, plus major refinements as follows:

- *Make the Data Infrastructure investment additional funding (0.25-0.5%), distributed as outlined in A. above.*
- *Keep the core VBP as a carve out/earn back amount (minimum 2% or higher), distributed as outlined in the VBP proposal*
  - *Invest “residual funds” in Pay to Share and Pay to Test in “raising all boats” on these measures as outlined in C. below*
- *Make further major investments for future improvement, combined with an expectation of returns in 3-5 years (savings through future rate cuts to correspond to future cost savings) – i.e. Budget Neutral over 3-5 years. This applies to incorporation of Efficiency measures into VBP.*

The proposal presented two alternatives for the “exchange rate” to translate the performance score into an Incentive payment – linear or nonlinear.

*We recommend that the linear exchange rate be used.*

- *Common sense, validated by our past evaluation work,<sup>2</sup> suggests that incentives only work if they are understood. The linear alternative is much easier to understand and predict,*
- *It will motivate facilities to improve, even those at higher performance levels.*

Another area where input was sought is the basis of payment.

*We can support using the operating DRG component as the basis IF the payment calculation leaves the other components intact.*

The proposal sets a policy decision point at 85% to define “top performers” to receive full VBP.

*If the proposal is implemented as presented, we would recommend lowering the full VBP amount to 65-75%. If our suggestions for investment in data infrastructures and use of residuals are implemented, the 85% figure is appropriate.*

### **C. How Should “Residual” Payments be Distributed? Option 3: Invest in the Future**

We suggest accelerating implementation by using residual funds for:

***Pay to Share (best practices):*** *The concept is to pay Top Performing hospitals to share their practices with other hospitals in their local region to help them rapidly improve.*

- *Residual funds in a local region would be available to Top Performing hospitals in that region to share their expertise. More residual = more need and resources.*
- *Keeping funds in the local region would make VBP an easier sell to Congress*
- *Funds could only be used by Top Performers to share with other local hospitals*
  - *One primary use would be providing back-fill time for front line staff sharing with their peers in other hospitals at a hands-on practice level*
- *Efforts would be coordinated through the local “Value Exchanges” announced by Secretary Leavitt in February – giving them a specific target and focus.*
  - *Match Top Performers and hospitals with needs in their expertise*
- *Top Performers can help “raise all boats” without paying out of pocket to do so*

***Pay to Test (new measures) Top Performers could also help test new measures and fine tune them for accuracy and ease of data collection prior to final evaluation and roll-out.***

- *These hospitals would be eligible for reimbursement for their staff efforts*
- *Top Performers serve as pool for type, region, and/or national sampling*
- *Top Performers can help “raise all boats” without paying out of pocket to do so*
- *(Note: As an alternative, Pay to Test could be moved to A. Data Infrastructure)*

***Note that Top Performers by definition are no longer eligible for cash VBP payments. Since both Pay to Share and Pay to Test are ways to reimburse hospitals for their additional costs, the actual benefit is non-cash Recognition. Top Performers value Recognition, and it gives them a reason to improve even when “topped-out.” It also changes the dynamics of competition to finding better ways to “raise all boats.”***

## **2. Measures of Value (Quality, Patient Experience, Efficiency)**

- *Incorporate differential weighting into HCAHPP measures, making HCAHPS worth 25-30% of the total range of performance.*

## **3. Data Infrastructure & Validation (How data for the measures are collected and audited)**

- *Perform a combination of random audits and targeted audits based on unusual case patterns identified within each hospital in the audit sample.*
- *Risk-adjust ALL targeted audits and measures and obtain inter-rater reliability to eliminate bias in pass-fail rates.*
- *Begin now to use available data from CDAC and other analyses to look for patterns and variability in future administrative measures under consideration.*

## **4. Public Reporting (Transparency for all Stakeholders – in a useful format)**

- *Structure consumer reporting to use composites that are easy to understand and focused on conditions and surgical procedures that are meaningful to consumer needs.*
- *Lists of “Pipeline” Measures that are seriously being considered for public reporting should be available early on, to help resolve unintended consequences that may arise from variability in reporting the data.*

## **Implementing Value Based Purchasing: *Policy Options, Practical Refinements* Discussion**

Value Based Purchasing (VBP), a refinement of Pay for Performance (P4P), is a major focus of efforts to improve effectiveness, patient experiences, and efficiency in the U.S. Healthcare delivery system. The target of these efforts is to better align incentives for all stakeholders, and thereby remove existing barriers to implementing necessary improvements.

The Deficit Reduction Act (DRA) of 2005 specifies that the Centers for Medicare and Medicaid Services (CMS) develop a plan to implement VBP for Medicare hospital payments for Federal Fiscal Year 2009 (FFY09 – beginning October 1, 2008.) On January 17, 2007 CMS held a Listening Session in Baltimore, Maryland to solicit oral testimony on a range of design questions for implementing the VBP plan. A second Listening Session at CMS was held on April 12, 2007 to solicit feedback on a draft Options paper. These efforts are focused in four major design areas:

5. Incentive Structure (Timing, Amounts, and Mechanisms for VBP payments)
6. Measures of Value (Quality, Patient Experience, Efficiency)
7. Data Infrastructure & Validation (How data for the measures are collected and audited)
8. Public Reporting (Transparency for all Stakeholders – in a useful format)

Next Wave (NWI) is a health services research and policy consulting firm located in Albany, New York. NWI staff spent over 30 years in the design, implementation, and evaluation of local, state, national, and international payment and quality measurement systems. Refinements recommended in this white paper are based on comprehensive project experience, spanning a broad range of stakeholder groups and delivery settings. They expand upon comments presented at and following the January Listening session<sup>3</sup> and the verbal comments presented at the April Listening session.

The Options Paper on Value-Based Purchasing presented at the April 12 Listening Session provides a good core framework for a value based purchasing program for Medicare hospital payments. We want to formally acknowledge the excellent work performed by the VBP team. The changes we saw between the January and April sessions are striking. What resulted is a very understandable system.

Our comments focus on specific areas where input was requested and provide recommendations for refinements. We believe our input can help the team tie the details together into a structure that is both understandable to the general public and acceptable to Congress for implementation.

### **1. Incentive Structure (Timing, Amounts, and Mechanisms for VBP payments)**

The reason for exploring value based purchasing is to provide a mechanism to encourage overall improvement. The proposed structure is simple, fair and likely to succeed. It will reward relative performance on both:

- **Attainment** of performance between a threshold (50-60%) and a “benchmark” goal
- **Improvement** in performance for hospitals that achieve at least minimum performance.

Including both a definition and method to address “topped out” measures are good design features.

We support the basic incentive payment design to reward past performance (“B.” below.) Our suggestions for refinement can best be visualized in relation to the overall Value Based Purchasing Model. We suggest refinements in both the data infrastructure (“A.” below) and how “Residual” funds are used (“C.” below.) We also recommend specific technical refinements in each area.

<b><u>A. Data: Build &amp; Maintain Infrastructure</u></b>	<b><u>B. Reward Past Performance</u></b>	<b><u>C. Option 3: Invest Residual in Future</u></b>
<b>Pay for Reporting</b>	<b>Pay for Attainment</b>	<b>Pay to Share</b>
	<b>Pay for Improvement</b>	<b>Pay to Test</b>
<b>Reimburse Cost Incurred</b>	<b>Incentive Payments</b>	<b>Reimburse Cost Incurred/ Recognition</b>

**A. Specifically Recognize the Need and Costs to Build and Maintain the Data Infrastructure**

The first major component of VBP is to build and maintain a data infrastructure to support the measures of performance. These measures can then be improved by providers, in turn improving the health care they deliver. All of the VBP payments so far to hospitals by Medicare have been “Pay for Reporting” under the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU). The CMS proposed VBP changes would simply require continued reporting of all the Attainment and Improvement measures as a threshold condition, without any specific payment tied to reporting.

A “Business Case” analysis of the data reporting cost vs. VBP return varies widely across facility bed size groups because much of the cost is fixed. At a VBP pool level of 2%, the fixed cost of data reporting may represent only 5% of potential VBP payments for large urban teaching hospitals but as much as 65% for small rural hospitals for hospitals that are above the top performer attainment benchmarks (higher percentages for hospitals receiving less than full VBP payments.) It can easily cost small rural hospitals with average performance more to participate than the hospital could possibly recover in VBP payments – a disincentive to participate.

*We recommend that “Pay for Reporting” be continued – at fixed amounts representing estimated fixed costs of reporting the VBP measures (e.g. initially set at \$50,000 for facilities under 100 beds, \$100,000 for facilities from 100-199 beds, and \$200,000 for facilities 200 beds and over.)<sup>4</sup> This would:*

- *Address small hospital “fairness” concerns,*
- *Support collection of performance data from ALL hospitals for policy analysis and transparency to consumers*
- *Allow an easier to understand linear “exchange rate” to translate performance score into payment*

We also note that the number and types of measures to be reported is planned to expand rapidly over the next few years, making the need to address these issues even more critical. Hospitals

reported 21 measures in 2006. By the end of 2007, this will expand to 49 measures (36 report categories including composites.) There are currently 105 hospital measures plus over 40 ambulatory measures in the pipeline at the National Quality Forum (NQF) for endorsement by year end. There could easily be 10 times the number of measures by 2010 than reported in 2006.

***We recommend that reimbursement for data infrastructure costs be additional payments outside the target VBP percentage and in addition to basic IPPS payments. This would:***

- ***Acknowledge the cost and value of any additional proposed measures.***
- ***Implicitly align and balance incentives so that only high value measures are incorporated (Everyone is willing to collect data that they are paid to collect. Likewise, whoever is paying for data will make sure it is worth asking for.)***
- ***Avoid future “un-funded mandate” push-back or more facilities opting out***

### **B. Rewarding Past Performance for both Achievement and Improvement**

The core VBP proposal addresses many of the issues raised in the first Listening session in January. Providing points for the higher of Achievement or Improvement, and only providing the maximum 10 points for measures where the hospital exceeds high level Benchmark performance, strikes a good balance of rewarding good practice for hospitals at various stages of implementation. Our comments address areas where the VBP team sought input.

Our primary comments address the size (e.g. 2% like the current RHQDAPU or some other value) and source of VBP funds. The modest 2% RHQDAPU (carve-out) and 1-2% Premier (add-on) amounts have generated measurable gains in process measures, although only minor gains in outcomes to date. Hospitals logically prefer add-on payments while Medicare and other payors logically prefer carve-outs. Each has arguments supporting their own position. Both are partially right. Successful non-healthcare businesses typically invest 5-6% on research and improvement each year, with periodic major investment funded by stock sales, with an expected return to investors in 3-5 years. Businesses that do not make these periodic and ongoing investments fall behind the competition and then fail. The lesson is disturbingly parallel to international healthcare cost and outcome comparisons. Other countries that have made major add-on investments in data infrastructure and quality improvement initiatives have better outcomes and lower costs than the U.S. We recommend a balanced investment in improving healthcare in the U.S.:

- ***Make the Data Infrastructure investment additional funding (0.25-0.5%), distributed as outlined in A. above.***
- ***Keep the core VBP as a carve out/earn back amount (minimum 2% or higher), distributed as outlined in the VBP proposal***
  - ***Invest “residual funds” in Pay to Share and Pay to Test in “raising all boats” on these measures as outlined in C. below***
- ***Make further major investments for future improvement, combined with an expectation of returns in 3-5 years (savings through future rate cuts to correspond to future cost savings) – i.e. Budget Neutral over 3-5 years. This applies to incorporation of Efficiency measures into VBP.***

The proposal presented two alternatives for the “exchange rate” to translate the performance score into an Incentive payment – linear or nonlinear. The linear option is easier to understand while the non-linear may be more accurate (easier to improve at low performance, harder to improve at

higher performance.)

*We recommend that the linear exchange rate be used.*

- *Common sense, validated by our past evaluation work,<sup>5</sup> suggests that incentives only work if they are understood. The linear alternative is much easier to understand and predict,*
- *It will motivate facilities to improve, even those at higher performance levels.*

Another area where input was sought is the basis of payment. The real issue is making sure that the basis of the carve-out and the basis of the VBP payments are consistent to avoid redistribution bias and patient access concerns. Some commenters suggested limiting the VBP percentage to only the operating DRG payment, with the presumption that other factors (capital, IME, DSH, etc.) would remain the same. However, care must be taken in the actual payment calculation process.

*We can support using the operating DRG component as the basis IF the payment calculation leaves the other components intact.*

The proposal sets a policy decision point at 85% to define “top performers” to receive the full VBP payment. The value could be higher if funds are add-on and perhaps should be lower if funds are carve-out/add-back as proposed.

*If the proposal is implemented as presented, we would recommend lowering the full VBP amount to 65-75%. If our suggestions for investment in data infrastructures and use of residuals are implemented, the 85% figure is appropriate.*

### **C. How Should “Residual” Payments be Distributed? Option 3: Invest in the Future**

Both the Achievement and Improvement payments outlined in “B.” above address past performance by facilities. For facilities other than the “top performers” defined by the policy decision point above, only partial payments would be provided based on the degree of partial attainment of the benchmark measures. Thus some “residual” funds would be available from the \_\_\_% carve-out. The VBP team requested input on how to distribute these funds, outlining:

1. Option 1: Distribute to all hospitals based on VBP Performance Scores
2. Option 2: Distribute to top performers only

In our oral comments, we suggested an alternative based on rapid cycle improvement which we termed “Option 3.” This is to distribute residual funds to top performers, but only for activities that will “raise all boats” in the future. We further linked Option 3 to the local “Value Exchanges” outlined by Secretary Leavitt in February. By doing so, local solutions can be applied to local hospitals. This is an added benefit when presenting VBP back to Congress for implementation approval. It would limit redistribution of Medicare funds across districts in both the short term and long term. The VBP team specifically asked us to expand upon Option 3 in our written comments.

In Option 3, we outlined two uses for the residual funds: Pay to Share (best practices) and Pay to Test (new measures.) Both:

- Focus on the future rather than the past,

- Provide further motivation to top performers to continue their improvement efforts rather than becoming complacent with being a top performer.
- Make the focus of this portion of VBP efforts the process of process improvement, including models of coordination and technology transfer of research into practice
- Accelerate development and dissemination of improvements – responding to stakeholders who want to see VBP implementation “as fast as possible”
- Help validate and apply solutions in the real world by hands-on provider staff rather than academic researchers – addressing concerns of the stakeholders who want to see VBP implementation “slow and careful to avoid unintended consequences”
- Require a cost investment by participating hospitals, but also provide reimbursement of these costs so that individual hospitals do not have to bear the burden of “raising all boats”
- Make use of proven expertise – hospitals that are top performers and already receiving full VBP payments. This avoids others the expense of reinventing the wheel
- Provides essentially free consulting to facilities that need it – addressing a frequently mentioned barrier to improvement (facilities needing improvement don’t have resources)

We suggest accelerating implementation by using residual funds for:

***Pay to Share (best practices): The concept is to pay Top Performing hospitals to share their practices with other hospitals in their local region to help them rapidly improve.***

- ***Residual funds in a local region would be available to Top Performing hospitals in that region to share their expertise. More residual = more need and resources.***
- ***Keeping funds in the local region would make VBP an easier sell to Congress***
- ***Funds could only be used by Top Performers to share with other local hospitals***
  - ***One primary use would be providing back-fill time for front line staff sharing with their peers in other hospitals at a hands-on practice level***
- ***Efforts would be coordinated through the local “Value Exchanges” announced by Secretary Leavitt in February – giving them a specific target and focus.***
  - ***Match Top Performers and hospitals with needs in their expertise***
- ***Top Performers can help “raise all boats” without paying out of pocket to do so***

One “unintended consequence” identified for VBP is that inevitably there will be local, regional, and state differences in achieved performance. When funds are only provided to successful hospitals, VBP will remove money from those localities that need investment to improve their performance and give it to localities that don’t need it to improve. Both Option 1 and Option 2 suffer from this unintended consequence – commonly referred to as the “death spiral” – lower performing facilities don’t have the resources to dig out. Option 3 addresses this concern.

Localities with lower performance will initially receive more money to facilitate improvement. The Top Performers receive it and the lower performing hospitals get free consulting. When improvements are implemented, the improving hospitals will receive VBP payments.

By keeping residual funds local, Option 3 facilitates sharing within a local region – there is more likelihood that specific practices will work in a local community served by all stakeholders. This is particularly critical for hospitals serving culturally diverse and underserved populations where interventions that work in other locales may not work here.

By keeping residual funds local, Option 3 also addresses political ramifications of any process that might redistribute federal funds. VBP will only be of benefit if it's implemented. This requires that Congress provide authorization to implement the proposed VBP system. In this process, each member will examine the impact on their own constituency. By making it neutral by design, it eliminates many of the potential Congressional barriers to moving forward with needed change.

On a practical side, in order to share practices, it is extremely useful to have staff that are actually implementing practices show their peers in other facilities how to translate these practices. However, the staff that already know the best practices are spending time implementing them in their own facility. There is no time available for them to share their expertise with their front-line colleagues elsewhere. One aspect of Option 3 would reimburse Top Performers to backfill staff time so that the true experts in the improvement processes (the people actually implementing them on a day-to-day basis) can work with their local colleagues to transfer the practices.

There is a need to field test new proposed measures at a practical level prior to implementation. Both accuracy and ease of data collection need to be assessed. This is typically done by seeking out volunteers to do the work. Many times it is difficult to find volunteers since it costs much more to field test new measures (typically several times) than to simply implement a mature measure with detailed specifications. Not only is cost a barrier, but field testing with anyone willing and available may not identify best practices or other unintended consequences. Targeting Top Performers to be a pool for field testing new measures, and reimbursing their costs to do so can address these concerns. We recommend:

***Pay to Test (new measures) Top Performers could also help test new measures and fine tune them for accuracy and ease of data collection prior to final evaluation and roll-out.***

- *These hospitals would be eligible for reimbursement for their staff efforts*
- *Top Performers serve as pool for type, region, and/or national sampling*
- *Top Performers can help “raise all boats” without paying out of pocket to do so*
- *(Note: As an alternative, Pay to Test could be moved to A. Data Infrastructure)*

Note that Top Performers by definition are no longer eligible for cash VBP payments. Since both Pay to Share and Pay to Test are ways to reimburse hospitals for their additional costs, the actual benefit is non-cash Recognition. Top Performers value Recognition, and it gives them a reason to improve even when “topped-out.” It also changes the dynamics of competition to finding better ways to “raise all boats.”

## **2. Measures of Value (Quality, Patient Experience, Efficiency)**

The HCAHPS patient experience measures will likely be included in the 2009 VBP measures. The patient's experience of care is a very important dimension, and is one we definitely believe needs to use differential weighting. If the process measures in use are worth 10 points each, HCAHPS should be worth a minimum of 50-60 points. This would make the HCAHPS patient experience measure worth 25 -30% of the total range of performance. Depending on the total number of measures used in a particular year, achieving an overall contribution for experience of care in this 25 – 30% range could be a result of simply using each of the various composite measures, or may require specific weighting (more or less points per measure) to achieve this range.

We feel this is important because after examining the history of CAHPS measures over time we have seen that the measures are highly correlated with engaging the patient including:

- Engaging the patient in their own care,
- Engaging the patient in adherence to medical advice, and
- Engaging the patient to openly tell caregivers what they need to know about that his/her medical history and other relevant information that will impact care and treatment.

The HCAHPS survey provides critical information and helps makes other areas more controllable. For example, we may not be able to control adherence directly. However, we can indirectly influence the patient by having better communication and engagement measures.

To address small number issues, when looking at multiple years, you may want to change the process a little bit and maybe separate achievement and improvement for some of the measures that are coming in for small facilities so that you get an extra year of data (e.g. HCAHPS).

### **Recommendation**

- *Incorporate differential weighting into HCAHPP measures, making HCAHPS worth 25-30% of the total range of performance.*

### **3. Data Infrastructure & Validation (How data for the measures are collected and audited)**

The incorporation of both targeted and random selection for determining hospital samples is very positive, as is increasing the overall sample size. Moving towards an annual validation is also positive, increasing the sample's reliability while minimizing the burden on hospitals.

A modification/refinement to the approach may prove valuable in identifying overall trends. Performing a combination of random and targeted case selection based on measures with unusual data patterns could also be done. This allows for identifying problematic issues even within the random selected hospitals. In the targeted facilities, it may be advisable to go beyond the targeted issues and do a random selection of cases to identify issues that are not yet on the radar. Targeted audits related to specific issues in combination with random case selection are the types of audits performed by fiscal intermediaries and QIOs.

Note that ALL targeted audits would require risk adjustment using differential inter-rater reliability with specific measures to avoid bias in pass-fail rates.

In the Listening session, there was some discussion on moving forward with VBP as quickly as possible. Others felt we should move slowly and carefully. It is possible to both accelerate the process while still being careful. On your list of upcoming measures for future years, most measures are driven by administrative data. It is advisable to start reviewing what you already have available in CDAC data from other analyses, and to begin looking at patterns that might indicate the need for additional validation. That can be done simultaneously, before the start of the formal data collection and reporting process. We have identified bad data which distorts several measures that are on the agenda for NQF validation, as we described using some examples our January comments.

#### **Data and Validation Recommendations:**

- *Perform a combination of random audits and targeted audits based on unusual case patterns identified within each hospital in the audit sample.*
- *Risk-adjust ALL targeted audits and measures and obtain inter-rater reliability to eliminate bias in pass-fail rates.*
- *Begin now to use available data from CDAC and other analyses to look for patterns and variability in future administrative measures under consideration.*

#### **4. Public Reporting (Transparency for all Stakeholders – in a useful format)**

We reiterate the value of composites from the consumer's perspective. Consumers want to be able to see the composite, but many do not need or even want to drill down to the details. From a composite perspective, most report card sites that are readily available provide data based on a medical condition or surgical procedure as these are the units consumers are interested in. The consumer wants to see who is ranked high for treating their condition or performing the specific type of surgery they need to have.

It is considered a bit of a 'chicken or egg issue' on whether consumers trust friends and neighbors versus report cards. However, every four years, AHRQ and Kaiser conduct a survey to determine how people make medical decisions. Consumer trust in government sources of healthcare information had increased significantly during the last survey. This is positive, and we are due for another round of the survey.

Another issue related to public reporting is looking at the pipeline of measures. HQA has their chart listing all of the various measures and when then they are likely to come online. The National Quality Forum now has its pipeline report which started this month, consisting of 5-closely spaced pages of various measures. We will have a plethora of measures this fall that we will need to choose from for future reporting use. Many of those measures are not in the normal HQA book of specifications that ensures consistent reporting, but are driven by administrative data with a wide variability of how data is reported. Therefore, it is important to know which measures on the list are seriously being considered for public reporting. This can help address potential unintended consequences earlier in the process to ensure accuracy and balance.

#### **Recommendation**

- *Structure consumer reporting to use composites that are easy to understand and focused on conditions and surgical procedures that are meaningful to consumer needs.*
- *Lists of "Pipeline" Measures that are seriously being considered for public reporting should be available early on, to help resolve unintended consequences that may arise from variability in reporting the data.*

We encourage readers to contact us for further details at:

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<sup>1</sup> Estimates included for this illustration were simply ballpark estimates for discussion purposes. A brief study to identify more accurate cost estimates can be conducted to refine them prior to implementation.

<sup>2</sup> For example, in structuring the Resource Utilization Groups (RUGS) demonstration payments in New York State in 1986, much time and effort was spent in the policy and design discussions regarding the incentive value of a complicated “corridor around the mean” feature. In a statewide evaluation after 10 years of RUGS payments, we found in regional focus groups that NONE of the participating Administrators responded to this “incentive” – or were even aware that it was considered an incentive.

<sup>3</sup> Implementing Value Based Purchasing: *Policy Questions, Practical Solutions* January, 2007. Next Wave, Albany, NY. (available at <http://www.nextwave.info/whitepapers/VBP-Next%20Wave%20Written%20Comments-final.pdf>)

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<sup>5</sup> For example, in structuring the Resource Utilization Groups (RUGS) demonstration payments in New York State in 1986, much time and effort was spent in the policy and design discussions regarding the incentive value of a complicated “corridor around the mean” feature. In a statewide evaluation after 10 years of RUGS payments, we found in regional focus groups that NONE of the participating Administrators responded to this “incentive” – or were even aware that it was considered an incentive.