What Physicians Think About Resource Use Reports

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Research Objectives

- Design and test confidential resource use reports (RURs) to physicians regarding costs for providing care to Medicare beneficiaries, as required under MIPPA

- Conduct formative research to inform the development RURs for dissemination
Program Objectives—Physician Resource Use Measurement and Reporting Program

- Provide physicians with resource use information that is meaningful, actionable, and fair

- Move toward value based purchasing, i.e., payment system redesign that links payment to quality and efficiency of care, public reporting to promote value
Methodology—Overview

- Three rounds of formative research during Fall 2008
  - Round #1—Baltimore, MD
  - Round #2—Boston, MA
  - Round #3—Indianapolis, IN

- In-depth interviews (IDIs) with 20-25 primary care physicians (PCPs), medical specialists, and surgeons per round
Methodology—Approach

- Visual elements—data tables and graphs
- Concepts—glossary definitions, understanding, and perceptions
- Design—full RUR and desired level of information
Methodology—RUR Concepts

- Costs included in RURs
- Risk adjustment and cost standardization
- Attribution of costs
- Calculation of costs and of episodes of care (commercially-available grouper) → per capita costs and per episode costs
- Cost comparison benchmarking
- Drilldowns by service category and hospital utilization
Methodology—Focal Conditions

- For episode-based costs
- High-prevalence and high-cost
- Chronic conditions—congestive heart failure, chronic obstructive pulmonary disease, emphysema, angina pectoris (chronic maintenance), and malignant neoplasm of the prostate
- Acute conditions—cholecystitis and cholelithiasis, acute myocardial infarction, hip fracture, community-acquired pneumonia, and urinary tract infection
Methodology—Full RUR

- Introduction
- Per capita costs and drilldowns, with benchmarks (tables and graphs)
- For each condition, per episode costs and drilldowns, with benchmarks (tables and graphs)
- Glossary
- Methodology
- http://rurinfo.mathematica-mpr.com/
## Sample Table Segment #1

<table>
<thead>
<tr>
<th>Year</th>
<th>Per Capita Costs of Your Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006</td>
<td>$4,425</td>
</tr>
<tr>
<td>2005</td>
<td></td>
</tr>
<tr>
<td>2004</td>
<td></td>
</tr>
</tbody>
</table>

| Per Capita Costs of Other Family Practice Specialists in Indiana  
 n = 1,956 Family Practice Specialists |
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>10th percentile</td>
</tr>
<tr>
<td>$1,638</td>
</tr>
</tbody>
</table>
### Sample Table Segment #2

<table>
<thead>
<tr>
<th>Service Category</th>
<th>Costs for Your Medicare Patients</th>
<th>Median Costs of All Other Physicians Treating CHF in Indiana</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>For Professional Evaluation and Management (E&amp;M) Services</strong> provided by you for your patients in all settings</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office or Outpatient Visits provided by other physicians treating your patients:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care Physicians</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>For Inpatient Hospital Facility Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>For Post-Acute Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>For Outpatient Hospital Facility Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinic or Emergency Visit</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Key Findings—Global Comments

- Few rejected outright the notion of RURs
- Many noted cost data should be combined with quality data
- Many unlikely to review in depth without compelling reason
Key Findings—Per Capita vs. Per Episode

- Most (both PCPs and specialists) preferred seeing both

- PCPs found more merit in per capita cost than did specialists

- However, many specialists raised questions about the ability to define episodes in an elderly population
Key Findings—Attribution

- Virtually all favored rule that assigned costs to multiple providers
- Many acknowledged appropriateness of responsibility for costs incurred by other providers, e.g., physicians, hospitals, post-acute
- However, should be costs over which had some control, e.g., prevention, referrals
Key Findings—Benchmarking

- Few expressed a preference
- PCPs somewhat favored more broadly defined peer group
- Specialists clearly preferred a narrower same-specialty peer group
- Most preferred local geographic benchmark
- Many concerned with comparisons to physicians with different patient mix
- More accepting of broader benchmarks that were adequately risk and price adjusted
Nearly all liked service category drilldown

Most noted would explain away categories over which they felt had little control

Initially felt reports too long, but then responded favorably to level of detail
Less physician resistance to RURs than anticipated, but more formative research could ensure they are meaningful, actionable, and fair for physicians

Primary concerns pertained to assignment of costs (both which costs and to whom), and cost information in the absence of quality information
Implications

- Physicians accept RURs as potentially valid and useful performance measures and guides for care delivery improvements.
- Validity and usefulness will be enhanced by combining resource use metrics with quality metrics.
- Electronic distribution will permit detailed information without length.
Implications

- Given concerns regarding range of attributed costs, physicians may be likely to support shared accountability (team attribution)

- Trade-off between scores or measures for physician feedback (detailed) vs. for payment (rolled-up or composite)