

**Payment  
Reform  
Series**

No. 2

**Advancing Transparency  
to Reform Payment:**

**The Top Dos and Don'ts from Regional  
Multi-Stakeholder Collaboratives**

Elizabeth Mitchell  
President and CEO  
Network for Regional Healthcare Improvement

Dianne Hasselman  
Senior Director  
Strategic Programs  
Network for Regional Healthcare Improvement

March 16, 2015

## **Advancing Transparency to Reform Payment:**

### **The Top Dos and Don'ts from Regional Multi-Stakeholder Collaboratives**

---

The Network for Regional Health care Improvement (NRHI) is a national membership organization representing more than 30 Regional Health Improvement Collaboratives (RHICs). These multi-stakeholder organizations are working to achieve better health, better care, and lower costs in their communities. This NRHI Payment Reform Series will address a range of issues impacting multi-payer, multi-stakeholder efforts to change how care is paid for in regions and states across the country.

## **Advancing Transparency to Reform Payment:**

### **The Top Dos and Don'ts from Regional Multi-Stakeholder Collaboratives**

#### **Overview and Purpose**

Too often, health care costs are opaque and hard to understand. When light is shone on cost and utilization at a local level, providers and other stakeholders may better understand the underlying cost drivers and evaluate opportunities for improvement. Providers who become conscious of their own costs and resource use—particularly in contrast to their peers—can take steps for more appropriate resource use.

Physicians are not the only ones who can benefit from transparency. To ensure accountability in health care quality and cost, all stakeholders should be at the table, setting priorities and aligning their work. Employers and health plans also play critical roles in improving quality and value. As purchasers, they create incentives that all too often create barriers to better care. If they want providers to keep people healthy, they need to reward care that enables that. When purchasers know about relative quality and cost, they can manage costs for their population. And with the right information, they can target incentives and payment effectively. This is the direct link between cost transparency and payment reform.

Creating greater awareness of quality and cost and advancing public transparency and accountability is a daunting undertaking, no doubt. This document features advice from leading RHICs, including ones in California, Ohio, Colorado, Maine, Minnesota, Oregon, and Missouri,

that have been advancing their communities toward greater transparency of cost and quality information for years and overcoming barriers of all kinds. Each point is a simplified summary of complex issues, but here are a few dos and don'ts discovered through their work.

### **1. Do expect tension.**

The recent demand for greater price and cost transparency has elicited different responses: some payers/carriers and providers say the industry is not ready for it; some providers are worried about how the information will be used; purchasers and consumers say they needed this information yesterday. This tension—while uncomfortable—can be productive to drive change. Embarking on greater transparency of quality and cost information requires complex change and asks providers, in particular, to change how they think about and deliver care. It also means asking health plans/carriers to take steps to advance the community good and share data and information sometimes considered proprietary. It requires patience from all sides and an awareness of contrasting and often conflicting perspectives, which, in turn, will demand skilled collaborative leadership.

### **2. Do expect to compromise.**

In a multi-stakeholder consensus process, everyone will need to compromise. This process is not about 'getting your way'; it is about reaching a mutual goal. Physicians and employers may have very different views on the type, content, and pace of transparent information. If both views are effectively shared and understood, a win-win solution is possible.

*The U.S. Office of Management and Budget defines a standard of consensus as:*

*"...general agreement, but not necessarily unanimity, that includes a process for attempting to resolve objections by interested parties, as long as all comments have been fairly considered, each objector is advised of the disposition of his or her objective(s) and the reasons why, and the consensus body members are given an opportunity to change their votes after reviewing the comments."*

### **3. Don't move too quickly.**

Time will be well spent investing in building consensus up front around the aims, measures, and methods. While an abbreviated process may be faster, it may miss the chance to address concerns and priorities. Because measurement and data aren't perfect, people will need to understand and accept their limitations—or they are likely to be a vocal critic of the end product. It is important to establish clear timelines, processes, and targets for advancing toward transparency. For example, it may help to start by privately reporting information to providers to allow time for validation and feedback with a clear timeline to initiate public reporting. A reasonable timeline between the first private report and the launch of public reporting might be 12 months. Predictability and consistency can help earn the trust and support needed to navigate the tension. And don't be surprised if tension mounts just before public release—even after a thorough process. Manage expectations and give stakeholders a role, timeline, and clear process for how reporting will be sequenced—and then move ahead.

### **4. Do insist on a neutral source of data.**

Transparency depends on a "source of truth" that everyone accepts and respects. No one stakeholder can generate an unbiased approach to data. A multi-stakeholder consortium with access to aggregated all-payer data and the technical expertise needed to produce fair and unbiased analytics is often essential to the sustainability of any measurement and public reporting program. Furthermore, because these efforts need to include multiple stakeholders to be effective, do ensure that the community's discussions occur within a multi-stakeholder forum with a skilled facilitator to ensure a balance of interests across stakeholder groups. RHICs can provide that trusted and neutral facilitation. Don't underestimate its importance.

## **5. Do recognize that the various stakeholders—purchasers, payers, providers, and consumers—have different motivations for cost measurement.**

For example:

- *Purchasers and plans/carriers* may prioritize outcome measures and the impact on cost.
- *Providers* may be more interested in a greater level of granularity of information—specifically information that is actionable with individual patients. Providers may also be more interested in process measures, which may represent specific actions within their control. They are also interested in this information to enable payment reform discussions.
- *Consumers* have their own perspectives—perhaps prioritizing information about out of pocket costs or safety-hospital-acquired conditions or infection rates, for example. Consumers clearly prioritize patient experience and communication. These may not be high priority for other audiences, but balancing interests is key.

Thinking through user needs and bringing together representatives of different viewpoints is imperative for designing an approach that meets the needs of the community and each stakeholder.

## **6. Do recognize that payers and the public expect quality performance.**

Quality is everyone's first priority when it comes to health care. The good news is that the quality measurement and reporting field is relatively mature and offers many lessons for sharing performance information. Be prepared to provide a vetted and auditable record of quality performance with risk-adjusted data. But demonstrating true value requires a balance of quality and cost. Increasingly over time, these quality metrics should be created by linking clinical and claims data.

## **7. Do measure and attribute patients in a way that enables improvement.**

If you want measurement to be valuable to providers, it is important to attribute patients to a provider or organization in a way that the provider understands and can use it. When asked to be accountable for performance tied to payment, providers are rightly concerned about which patients will be included and attributed to them. It is fair to say that no attribution method is perfect—some patients may be incorrectly attributed in any approach. However, experience and data show that for population-level measurement, what is most important is that the methods are transparent and fully explained so that all stakeholders understand and can work within their limitations.

## **8. Do have specific asks of carriers/plans.**

Providers will likely have needs for additional information to help them make improvements. Access to all-payer claims data by a trusted community source may be the most efficient way to provide the needed information. This can ensure that providers or other stakeholders have the opportunity to verify information down to the patient level and ask additional questions about the performance results. Providers will need data on a regular and frequent basis. Quarterly or semi-annual data might be appropriate. Also, do ask plans and carriers to use data and measures that all stakeholders find credible and valuable. Ask carriers to adopt community-endorsed measures, and ask local purchasers to drive alignment of strategies and use the publicly reported information when they design payment incentives.

## **9. Do identify measurement priorities—and the key information needed—as a community.**

Pick a reasonable and manageable number of measures. Somewhere between five and 10 quality measures matched to cost measures can be a good place to start and can help providers to prioritize. This

requires some parties to 'give up' their preferred measures but it enables focus and impact. This requires a community convener because often measurement programs are designed without knowing what other actors are doing—unintentionally creating competing and unproductive demands on providers. The measure set should reflect the various domains of interest to purchasers, payers, providers, and consumers, which may include quality, safety, cost, patient experience, and others. The goal is a balanced portfolio of measures across these domains that provides important information without overburdening all parties.

#### **10. Do expect increasing accountability that links payment to provider performance.**

The health care industry is headed toward greater cost transparency, primarily because the status quo is unsustainable. However difficult, this new course is unlikely to change. Be proactive and brave, and know that there is a network of communities also traveling toward transparency and ready to share their learnings. Likewise, for those who remain dubious about transparency, resist the urge to spend your energy criticizing the methodologies proposed and discussed. Instead, come to the table with the goal of ensuring that information will be reliable, credible, and useable. Measurement isn't perfect, but that doesn't mean it isn't valuable.

#### **11. Don't expect measurement to solve every problem.**

Measurement is a tool—a critical one—but only one of many levers needed to drive transformation. Providers and stakeholders will need data, education, and technical assistance to understand and use the tools. A trusted source is a great place to build those community resources. Other levers that must be pulled include federal and state policy, benefit design, value-based purchasing, and changes in payment, consumer engagement, and more. Transparent community measures should enable and inform all of these strategies. This underscores the importance of having all stakeholders, who each control different levers, at the table.

## **12. Don't assume stakeholders have the experience, training, time, or resources to know when and how to use the quality or cost information generated by public reporting.**

Identify the support and technical assistance that providers—and purchasers—will need to engage in the process. Furthermore, don't expect things to change overnight. The barriers faced by providers to change care delivery are significant, and include the current payment system that often penalizes better care at lower cost. Information is the necessary first step to a comprehensive change process that must align strategies for payment, patient engagement, benefit design, culture, and other social needs.

## **13. Lastly, do get on with it!**

Don't wait for perfect data, measures, or methods. Your community can drive change now with the tools we have today. A fundamental misunderstanding about transparency—which goes hand-in-hand with payment reform—is that it requires perfect information and performance. While fairness and validity are critically important, greater transparency is about shining light on the reality of performance today in order to establish a path to advance forward. There will be variation across providers, regions, populations, etc., and there is no infallible methodology. This does not necessarily negate the validity of the results because providers can use information for discussion, comparisons with peers, and improvements in care. And while major change has to occur over time, it's unrealistic to only dip a toe into cost transparency and then expect results.

There are more than 30 RHCs across the country, with new collaboratives forming all the time. These nonprofit, non-governmental organizations can be invaluable partners in this challenging endeavor. For more on regional collaboratives, visit [www.nrhi.org](http://www.nrhi.org).

## Acknowledgements

---

Thank you to the following Regional Health Improvement Collaboratives for their leadership, investment, and insights in exploring transparency of cost information as one of the ways to accelerate payment reform in our health care system:

- [Center for Improving Value in Health Care](#) (Colorado)
- [Integrated Healthcare Association](#) (California)
- [Maine Health Management Coalition](#)
- [Midwest Health Initiative](#) (St. Louis)
- [Minnesota Community Measurement](#) (MNCM)
- [Oregon Health Care Quality Corporation](#)
- [The Health Collaborative of Greater Cincinnati](#)