



Measuring Healthcare Value at the State Level: A Call to Action

Consumers in the U.S. are worried about high healthcare prices—and for good reason. The evidence is very strong that we overpay for healthcare, receive too many low-value services and outcomes are not uniformly high. Getting to better healthcare value is critical to reaching our nation's goal of broad access to quality healthcare for all, whereas overspending burdens for household, employer, and state and federal budgets.

States are key system actors likely to be at the forefront of meaningful progress on healthcare cost and value issues because the specific conditions that give rise to high prices, unnecessary services and uneven quality vary tremendously

between and within geographic areas. Yet most states are not equipped to address poor healthcare value on behalf of their residents.¹ Specifically, the absence of timely and reliable public data limits their ability to identify healthcare cost drivers, poor-quality hot spots and whether or not interventions designed to improve healthcare value are working.

This report is a *Call to Action* that details the types of data that should be collected at the state level and provides best-practice examples—proof-of-concept that systematic measurement of healthcare value is already taking place in selected states around the country.

SUMMARY

States play a critical role in the provision of healthcare to their residents, yet few states are armed with the data that would allow them to comprehensively assess or address the poor healthcare value faced by many families.

This report is a *Call to Action* that details the minimum five domains states should track as part of broad commitment to better healthcare value for their residents (spending, affordability, outcomes, medical harm and patient experience). It describes the key analyses that should be performed at the state level and provides "proof-of-concept" case study examples of states that already collect this critical data.

As described in the Hub's companion report, *Measuring Healthcare Value at the State Level: Advocates' Guide*, some state-level data is already widely available. But the picture is incomplete and states must do their own data collection to fill the void.

What is Healthcare Value?

Healthcare value is receiving quality care for a fair price. We must stop overpaying at the household, employer and governmental levels because, at the end of the day, the consumer is paying the bill.

Getting to healthcare value means we use our system's resources wisely, including investing appropriately at the community level, to achieve high-quality, equitable health outcomes; preferences and needs of consumers/patients are revealed and taken into account, and our healthcare system is transparent with respect to best practices, prices, quality and outcomes.

Ideally, states would have policies in place that would enable consumers to navigate the healthcare system safely and confidently. This means that data on price and quality is trusted, actionable and readily available, and the risk of encountering poor performers, or an outrageously inflated price, is minimized.

Finally, a properly working healthcare system is sensitive to consumers' varying ability to pay for the care they need. Healthcare, after all, is not a luxury, but a vital service necessary for life and quality of life.

How are Consumers Harmed by Poor Healthcare Value?

Addressing poor healthcare value is an urgent problem. The high cost of care and uneven quality have a profoundly negative impact on the health and financial security of American families.² Unaffordable prices for care can lead consumers to delay getting needed care and cause unwelcome budgetary tradeoffs, medical debt and sometimes bankruptcy.

Periodic surveys by the Kaiser Family Foundation reveal that half the U.S. population goes without needed care due to concerns about the costs. And one quarter of Americans have trouble paying their medical bills.³

High medical bills don't just keep people from filling prescriptions and scheduling doctor's visits. They can lead to deep financial and personal sacrifices, affecting families' housing, employment, credit and daily lives. A January 2016 Kaiser Family Foundation study showed the many major impacts, including the ability to pay rent or mortgage, or cutting back on food.⁴ Moreover, broad access to coverage and getting to better healthcare value are two inseparable, intertwined policy objectives. The more we can get for our healthcare dollar, the easier it is to achieve broad coverage of all Americans.

But unlike other products and services we buy, spending more on healthcare hasn't led to better quality. It is widely believed that between 15 and 30 percent of healthcare spending is considered waste.⁵ Most concerning, the CDC estimates that more than eight million hospital patients are subject to largely preventable medical errors and infections that cause harm ranging from minor to permanent disability to death. This harm can significantly affect people's lives—they may require years of additional care and can subsequently lose their jobs or their homes.⁶

Poor healthcare value contributes to disparities in access to coverage and the ability to pay. Lower-income families are less likely to have health insurance to help with medical costs. Further, when lower-income families do have employer coverage, health premium increases (being a fixed expense) absorb a larger share of the employee's compensation compared to higher-income employees. That said, the burden of high costs is felt well up the income ladder.⁷

For these reasons, the cost of healthcare is a top-of-mind concern for consumers. Recent polls show that Americans

are more concerned about healthcare than immigration, gun policy, education, Supreme Court appointments, trade policy, the environment and abortion.⁸

Why States Should Measure Healthcare Value

Due to the consumer harm described above, including the impact on coverage objectives, healthcare value merits the immediate and sustained attention of state policymakers, for reasons of consumer.

A large body of research shows that the cost, utilization, and quality of healthcare varies significantly, both across and within geographic regions.⁹ For instance, the amount of post-acute services used among Medicare beneficiaries can vary two fold between geographic areas.¹⁰ Likewise, prices for services can vary dramatically between different states and between relatively small regions within states. For example, the average cost of an ultrasound is \$522 in Cleveland, while sixty miles away in Canton the same procedure averages just \$183. Not only is price and utilization variation substantial and widespread, research has found little to no association between the level of spending and quality of care received.¹¹

While population health can explain some of these variations, a large portion remains unexplained, even after controlling for age, sex, race, and health status.¹² This has led many to conclude that fundamental inefficiencies in health systems are causing certain regions to spend more and get less; for example, the amount of market competition, state health laws, physician prescribing behavior, and payment incentives. Recall that Atul Gawande, famously compared two demographically similar cities in Texas: McAllen and El Paso. In his 2009 New Yorker article, Gawande found that Medicare spending in McAllen was twice that of El Paso. In fact, McAllen was one of the most expensive healthcare markets in the country, largely because physicians were focused more on volume of services than effectiveness of care.¹³

Given that the mix of factors that drive variations in cost and quality are unique to each state, states are well positioned to influence their local healthcare spending and quality patterns. But to understand and address these challenges, states need to take ownership of this issue that is negatively impacting and angering their citizens. To do so, regulators and policymakers need access to timely, reliable

data and metrics that accurately describes their state's unique challenges. For example,

- If spending variation is largely due to regional differences in underlying health status, then states should focus on the causes of poor health, including lifestyle factors, but also access to healthcare, community planning, public health investment, and educational and work opportunities.
- If the variation is largely due to health systems and practice pattern differences, then states need to focus on things like putting evidence into practice, performance monitoring, payment incentives to motivate change, and fostering organizational structures that promote high-quality, efficient care.

A Call to Action: Healthcare Value Accountability and Measurement by States

Consumer Reports and the Healthcare Value Hub call on states to address healthcare value on behalf of their residents. Specifically, states need to acknowledge their unique role in addressing poor healthcare value for their residents and to take ownership of this issue by:

- collecting and publishing data to fully understand the specific local causes of poor healthcare value, starting with the five key domains found in Table 1;
- establishing goals for improvement;
- measuring progress over time; and
- establishing remedies to address remaining gaps in healthcare value when goals are not met.

Beginning or expanding measurement and implementing a system of accountability may seem like a daunting task. But, as described below, many states are already performing one or more of these measurement tasks and many have acknowledged a state role for one or more the healthcare value domains of Spending, Affordability, Health Outcomes, Medical Harm and Patient Experience.

- But not all data collection and accountability efforts are created equal. As enumerated in the examples of state efforts below, we note how well they perform on the following dimensions:
- Do the data capture the detail needed to track progress in reducing **health disparities**? This includes collecting and

analyzing data such as race, ethnicity, family income and insurance status.

- Is the **data publicly available**? While there may be arguments for temporarily shielding some data while system kinks are worked out or to provide a short window for poor performers to improve their data, in general the power of data and reporting is greatly enhanced by making it publicly available.
- Have **targets or goals** been established with respect to the five healthcare value domains? To demonstrate their commitment to improve healthcare value for consumers, states should establish targets, even if voluntary, that define their vision for success.
- Are there **remedies** if targets are not achieved? If the efforts to measure progress and create goals—along with purchaser efforts to control spending and improve value—are insufficient to improve healthcare value, as defined by the state targets, then states should consider triggering state-sponsored remedies to address remaining gaps in healthcare value. Simply by publicizing this possibility, we would expect further progress on healthcare value.

Finally, we note that simply measuring various aspects of healthcare value can bring about improvements.

Measurement Results in Change Case Study (NY):

New York was among the first states to compare hospital mortality for coronary artery bypass grafts (CABG) and publicly report the data. When the early reports were issued, hospitals with substantially higher mortality rates responded by examining their surgical systems and identifying areas of improvement. Winthrop University Hospital on Long Island fared poorly among heart programs, so it hired a renowned cardiologist to overhaul its program, hired additional staff, and created a new database system to monitor quality of care. Within two years, the hospital's cardiac program had one of the state's lowest mortality rates.¹⁸

Healthcare Value Domains

Below are descriptions and discussions of the five major domains for measuring healthcare value and case study examples of states that already collect this critical data.

Table 1: Domains for Measuring Healthcare Value

Domains	Description
Spending	Researchers have conclusively shown that over spending on healthcare has a unit price component and a utilization component. For the same type of patient, same diagnosis, same service, prices vary tremendously and are, in fact, the largest single cause of year-over-year increases in spending. ¹⁴ But over-utilization is also a large problem which exhibits tremendous local variation. ¹⁵
Affordability	It is imperative that aggregate health spending be brought in line with the overall growth of the state's economy, but the resultant savings must also flow back to consumers. Put another way, these changes must be perceived as improvements in the affordability of healthcare. Further, the ability to afford care must be broadly distributed across income, racial and ethnic groups.
Health Outcomes	It is well documented that the high costs we pay for healthcare do not result in better health. ¹⁶ Clinical interventions account for just a portion of these outcomes, with social determinants of health increasingly recognized as another key factor. Establishing metrics to measure improvements in health outcomes over time—particularly outcomes that are affected by our health, public health and social services spending—is integral to understanding whether we are spending our healthcare dollars wisely.
Medical Harm Reduction	<i>To Err is Human</i> detailed the prevalence of medical harm in our system (hospital acquired infections, diagnostic errors, medication errors, never events and more). ¹⁷ Little progress has been made since the report's 1999 release. It is one of the most unforgivable lapses in state oversight.
Patient Experience	Patient experience can be very different from outcomes and is broader than just patient satisfaction. For complete success, our providers must be nimble enough to uncover patient preferences and incorporate them into the patient's treatment options and experience of care.

Healthcare Spending

The high cost of care and uneven quality have a profoundly negative impact on the health and financial security of American families. Excess healthcare spending forces trade-offs between more important purchases and burdens individuals, employers and governmental budgets.

Measuring healthcare spending in the aggregate is important because it reveals the most complete healthcare value picture and ensures that savings realized in one service area do not inadvertently lead to higher spending elsewhere, with no net savings returned to consumers.¹⁹

Failure to Address Aggregate Spending Case Study (MD):

Prior to 2014, Maryland's all-payer hospital rate setting approach successfully restrained growth in prices, moving from an average cost per hospital admission that was 25 percent above the U.S. average to the middle of the pack and largely realizing the state's goals. However, the cost per capita for hospital services grew rapidly, largely because hospitals responded to unit price constraints by increasing the volume of services more than other states. Under a new approach that began in 2014, hospital spending goals are specified differently, with the expectation that total spending on hospital care will rise at a lower rate.²⁰

Total Spending Case Study (MA): The Center for Health Information and Analysis (CHIA) is one of the few state initiatives that calculates annual total healthcare expenditures. This measure includes all healthcare expenditures for Massachusetts residents from public and private sources. As an example of their work, in response to increased prescription drug spending, CHIA put forth several state-level strategies, including group purchasing options, rebate and transparency efforts, and considerations for the state benchmark and alternative payment options to help address this high spending area.²¹

Price Variation Case Study (CO): The Center for Improving Value in Health Care (CIVHC) analyzed payment variation by payer for hip and knee replacements in Colorado.²² The report found that many Coloradans paid significantly more than Medicare for the same service, and private payer costs varied significantly across the state. The report's authors recommended that higher-cost regions explore what drives increased spending locally, and to investigate how lower-cost regions keep costs down.²³

Utilization Variation Case Study (CO): CIVHC also examined overall cesarean delivery rates and amounts paid by different payer types in Colorado and found that commercial payers have disproportionately high rates.²⁴ CIVHC determined that Colorado could realize sizable cost savings by reducing the rate of elective C-sections and modestly reducing the overall rate of cesarean deliveries.²⁵

While deep dives into the price and utilization patterns of specific services are useful, states should also separate growth in total spending into its utilization and price components, as is done nationally by the Health Care Cost Institute, a nonprofit dedicated to research and analysis of the causes of rising U.S. health spending.²⁶

Another analysis that would help get to better healthcare value is understanding the prevalence of low- and high-value care services in a state.

Low-Value Care Case Study (VA): Virginia Health Information (VHI) analyzed low-value care within Virginia using the MedInsight Health Waste Calculator. VHI reported the amount of wasteful spending by geographic region and compared it to the state average.²⁷ For 43 measures, the report showed use of services and spending by geographic region.²⁸ Reporting on health disparities is essential to achieving health equity. In the spending domain, reporting on health disparities becomes important because unnecessary spending can disproportionately affect communities of color, lower-income families and the uninsured.²⁹

Disparities Case Study (FL, WA): The Florida Center for Health Information and Policy Analysis studied potentially avoidable adult emergency department visits based on gender, race, and ethnic subpopulations to determine utilization patterns and access to primary care services in urban and rural areas of Florida.³⁰ The report found gender and racial and ethnic differences existed in potentially preventable ED visits in rural compared to urban counties in 2008.³¹ Similarly, the Washington Health Alliance measured utilization differences for avoidable ED use.³² The report highlighted the reasons why potentially avoidable ED use exists for different age groups, residents in geographic areas, and among hospitals, medical groups and primary care providers.

Disparities Case Study (VA): A report by the Virginia Department of Health found that substantial economic costs resulted from health disparities across socioeconomic, racial and geographic groups.³³ The costs represented lost opportunities to invest in the health of all Virginia residents. The report found that poverty reduction or increased education may significantly reduce health related economic losses to the state, since the costs of education-related health disparities are the equivalent of about ten percent of costs associated with the entire healthcare sector.³⁴

Once states understand healthcare spending flows, policymakers should consider crafting spending targets (even if voluntary) in order to determine whether the state is making progress on healthcare value over time. These goals could tie health spending growth to overall per capita growth in the state's economy or to a fixed budget based on factors including past expenditures, past clinical performance, and projected changes in level of services, wages, and population growth.

Setting Spending Targets Case Studies

(MA): In 2012, Massachusetts set health spending targets tied to the growth in the state's economy. The Massachusetts Center for Health Information and Analysis (CHIA) compares growth in total healthcare spending per person to a benchmark set annually by the state's Health Policy Commission. Massachusetts slightly exceeded its total health spending goal of 3.6 percent in 2015, coming in at 3.9 percent. However, the rate is down from the previous year (4.4%) and Massachusetts' total health spending rate is growing slower than the national average (4.6%).

Setting Spending Targets Case Studies

(MD): When Maryland modernized its all-payer hospital waiver from CMS in 2013, the state included a cap on per capita hospital cost growth for inpatient and outpatient care at 3.58 percent each year, which was the average growth rate of the state's gross domestic product during the past decade. The state also agreed to a special readmissions reduction program and a 30 percent reduction over five years in 65 potentially preventable hospital-associated conditions.

Setting Spending Targets Case Studies (VT):

Vermont's recently launched All-Payer Accountable Care Organization Model—also using a CMS 1115 waiver—will pay providers global rates determined by the patient populations and health outcomes. The model limits annual per capita expenditure growth to 3.5 percent and Medicare growth to at least 0.1 to 0.2 percentage points below projected national growth.³⁵

Finally, states may want to have remedies that are triggered if spending goals are not realized. The Massachusetts spending targets described above are voluntary. Maryland, on the other hand, faces important consequences if it fails to hit the hospital per capita spending targets—the loss of its waiver from CMS.

For maximum effectiveness, spending should be publicly reported. Public reporting mechanisms can increase awareness, accountability and help ensure the wide participation of stakeholders in the state's process. All the efforts described above are publicly available.

Affordability

When faced with unaffordable costs, people choose not to fill essential prescriptions, undergo necessary diagnostic tests or procedures or see specialists out of fear of financial harm. Moreover, concerns about affordability remains the overwhelming reason that people do not sign up for insurance coverage.³⁶

It is therefore imperative that state action to address high healthcare costs and uneven quality flow through to consumers' pocketbooks, directly increasing the affordability of needed care and premiums.

Unfortunately, our nation does not have a standard definition of healthcare affordability and few states have taken up the question. In light of the well documented consumer harm caused by unaffordable premiums, and high out-of-pocket costs, a key component of our *Call to Action* is for states to directly address the affordability of care and of premiums for their residents. States need to standardize how they measure and make progress on healthcare affordability.

Until states define affordability, other metrics can serve as strong signals of affordability problems, such as survey data that shows residents delaying care due to concerns about cost. Being uninsured or under-insured are also strong indicators of possible affordability problems.

As described in the Healthcare Value Hub's companion *Data Guide*, several measures of this type are already collected at the state level by the federal government.³⁷ One source, the Behavioral Risk Factor Surveillance System (BRFSS), is a data collection partnership between the CDC and state health departments. Each year, states can choose to add several optional modules to their core surveys. States can also add questions to the survey to meet their specific needs, if they pay the expense of the added questions. However,

the data currently collected is often not robust enough to explore disparities in affordability. This could be addressed by collecting larger sample sizes.

Few states collect affordability data over and above these federal collection efforts. One exception is Massachusetts.

Affordability Case Study (MA): In conjunction with the state's early universal coverage reforms, the Blue Cross Blue Shield of Massachusetts Foundation in 2006 began a periodic survey in English and Spanish of nonelderly adults called the Massachusetts Health Reform Survey. Among other things, this survey provides a strong assessment of affordability problems facing residents. This information is publicly available and includes demographic detail that permits some assessment of disparities.³⁸

Neither states nor our nation currently have explicit goals with respect to the affordability of care for residents. In part, this reflects the absence of standards against which to measure progress. But without such goals, consumers are unlikely to realize progress on this healthcare value domain.

Health Outcomes

Unfortunately, the evidence is strong that year-over-year increases in healthcare spending have not resulted in better health status or better clinical outcomes—nor has it reduced disparities.³⁹ It is critical that states monitor and improve outcomes in conjunction with their efforts to address high healthcare spending.

Compared to other domains of healthcare value discussed in this report, there is already a good amount of nationally collected data on state-level health outcomes.⁴⁰ What's more, many states have quality goals (State Health Improvement Plans), often modeled on the federal Healthy People 2020 framework.⁴¹

For purposes of measuring progress on healthcare value specifically, states should collect data and publicly report on the subset of health outcome measures that are most directly influenced by the use of healthcare services, such as prevention, chronic illness treatment and acute care services.

We also recommend that specific spending initiatives be accompanied by corollary outcomes measures to ensure

that spending targets are not realized by simply limiting services. For example, if knee replacements are the target of a statewide effort to reduce price variation, the state may want to track *Total Knee Replacement Outcomes*, which tracks changes in functional status as measured by the Oxford Knee Score three months preoperatively and at one year postoperatively.⁴² Further, data on outcomes must be representative of the entire population, not just the Medicare and Medicaid population.

Outcome Metrics Case Study (WA): In 2014, the state of Washington used a multi-stakeholder process to develop a set of statewide core quality measures track health and healthcare performance as well as inform public and private healthcare purchasers. Of interest, the state identified population health measures and clinical measures but could not provide cost measures. Specifically, the state recommended using multi-payer data to measure healthcare costs.⁴³

It is critical for the outcome data to be publicly reported. States currently make a significant amount of data available but with varying degrees of usability. Best practices include:

- Data is easy to find, timely, accessible and free.
- Simple explanations for why the measure is important, and context such as comparison to state or national averages, state goals or changes compared to previous years.
- Key demographic detail, such as race, ethnicity, income, insurance status and location, is available.

Outcomes Reporting Case Study (NY): An interactive website maintained by the state presents outcome measures by county, such as the All-Payer Potentially Preventable Emergency Visits. For many measures, the website displays the statewide risk-adjusted average and several years of data so residents can easily assess whether measures have changed dramatically or remained relatively consistent.⁴⁴

Disparities Reporting Case Study (CA):

California's Open Payment Portal, funded by the California HealthCare Foundation and maintained by the California Health and Human Services Agency, presents some data with unique categories, such as ethnicity, household income, and year.⁴⁵ A new California law requires the state Department of Public Health to break down demographic data it collects by ethnicity or ancestry for Native Hawaiian, Asian and Pacific-Islander groups. The law will better expose healthcare disparities and enable researchers, policymakers and advocates to better identify, track and address health disparities that affect specific ethnic groups.

As noted above, many states have quality goals—for example, State Health Improvement Plans—often modeled on the federal Healthy People framework. For example:

Outcome Goals Case Study (MA): The Health Policy Commission in Massachusetts identified the need to lower the rate of preventable hospital readmissions. Reducing readmissions is important to improving the health of the community and to reducing unnecessary costs. The state participated in new initiatives with the goal of improving readmission rates through better coordination.⁴⁶

Outcome Goals Case Study (NY): The New York State Prevention Agenda Dashboard compares the state's progress on a wide variety of measures to established goals. Users can see whether a measure has improved over time, experienced no significant change or worsened.⁴⁷

Outcome Goals Case Study (OR): The State Health Improvement Plan by the Oregon Health Authority establishes a set of priorities, goals, strategies and measures for improving health within the state by 2019. Oregon's priorities were selected based on the leading causes of death in Oregon. The report displays data highlighting disparities in sex, race, age and county.⁴⁸

Medical Harm Reductions

Medical harm is a remarkably common but poorly addressed problem. Although estimated to be the third-leading cause of death in the U.S.,⁴⁹ surprisingly little is done to measure, study and address the full spectrum of medical harm that impacts the lives of millions of people every year.

Medical harm refers to healthcare-acquired infections and all types of medical errors, such as:⁵⁰

- Serious reportable events—more commonly called “Never Events;”
- healthcare-acquired conditions;
- medication errors; and
- diagnostic errors.

Medical harm, by definition, is largely preventable, causes injury to patients and was proximately caused by the delivery of care. It therefore deserves special attention as a stand-alone domain of healthcare value.

In 1999, the Institute of Medicine called on states to create mandatory reporting systems as part of a strategy to identify and learn about medical errors and ultimately to improve patient safety.⁵¹ But that has never been done. Transparency and patient safety are correlated. Many believe that public reporting creates pressure for change; conversely, a system that does not acknowledge error will not be as motivated to address mistakes. Progress is enhanced by organizational cultures that emphasize safety rather than blame.

Patient Harm Reporting Case Study (MN):

The Minnesota Department of Health publishes facility-specific information about patient harm on its website. Seventy-two percent of Minnesota facilities surveyed in 2008 felt that the Minnesota error reporting law made them safer than they had been when reporting began in 2003. One provider respondent said, “(Our) focus was always on patient safety, however now safety efforts are better understood by more of our staff and we prioritize this work ahead of other work. Data is helping us to create more sense of urgency for this work.”⁵²

Healthcare-acquired Infections

Currently 32 states plus the District of Columbia have laws with some kind of prevention or reporting requirement pertaining to hospital-acquired infections and these laws have led to important improvements in infection prevention.^{53,54}

HAI Case Study (PA): Pennsylvania was one of the first states to require reporting and public disclosure of healthcare-associated infections (HAI's).⁵⁵ Pennsylvania is also one of the only states that mandate reporting from both hospitals and long-term care facilities. The requirements specifically target MRSA by requiring screening of high-risk individuals. The state achieved an eight percent decrease in HAIs between 2008 and 2010.⁵⁶

Serious Reportable Events

The National Quality Forum (NQF) publishes a list of recommended serious reportable events (“adverse” or “never” events) every five years with the goal of reducing the frequency of these rare but extremely serious errors. While 27 states, plus the District of Columbia, have systems to monitor the occurrence of adverse events, only fifteen states have utilized some, or all, of the NQF list for their reporting system, and even fewer publish hospital-specific information. The remaining 12 states use state-specific lists or AHRQ’s patient safety indicators.⁵⁷

Serious Reportable Events Case Study (MA): Massachusetts is the only state that requires reporting to two agencies, the Department of Public Health (DPH) and the Massachusetts Board of Registration in Medicine (BOIRM). While sometimes burdensome, the argument has been made that reporting to two systems is useful. Unlike the adverse events submitted to the DPH, which publishes an annual report with facility specific data, the BOIRM is completely confidential. This allows the agencies to look at statewide big picture issues and keep patient safety as a high priority. Facilities are required to conduct a Root Cause Analysis and a Corrective Action Plan.⁵⁸

On the whole, states have far to go in terms of strong public reporting on medical harm and a commitment to reductions in harm. With the notable exceptions of limited adverse events and hospital infections described above, much of the harm experienced by patients is simply not reported, including medication errors and diagnostic errors, as well as harm that occurs outside a hospital’s walls.⁵⁹ Moreover, it is widely acknowledged that there is significant under-reporting of errors and infections, not curbed by systematic validation of the reported data. Validation, generally through random chart audits or regular comparison to claims and billing data, counters systematic underreporting by participants. Finally, states should consider systems for collecting patient reported outcomes on medical harm—both infections and medical errors.

Broad Reporting Requirement Case Study (CO): Colorado requires reporting on all licensed healthcare facilities, including long-term care facilities, hospice, birth centers, emergency centers, clinics, acute treatment centers, and homes for the intellectually and developmentally disabled.⁶⁰

There is some evidence that adverse events may affect patients with limited English proficiency more seriously because of language barriers, but current state-level efforts to deal with medical harm do not appropriately measure and address these disparities.⁶¹ More research is needed to explore the impact of medical harm on minority and low income communities.

Finally, in far too many states public goals for reductions in medical harm have not been established and when they exist, even fewer require public accountability regarding results. State should push to establish more robust and transparent reporting systems to consumers can make more informed decisions when choosing a medical facility.

Medical Harm Reduction Goal Case Study (MD): When Maryland modernized its all-payer hospital waiver from CMS in 2013, the state also agreed to a special readmissions reduction program and a 30 percent reduction over five years in 65 potentially preventable hospital-associated conditions.⁶²

Patient Experience

Patient experience attempts to capture patients' preferences, documenting the aspects of care that often matter most to patients, such as timely access to care, good physician-patient communication, comfort and convenience.

Asking patients directly about their experience with healthcare providers yields important complementary data to the other clinical process and outcomes measures used to gauge quality. While administrative and clinical data can be used to measure medical quality, patients themselves typically are the best source of information to assess patient-centered aspects of care. Furthermore, it is critical to independently assess patient experience as these measures are not always strongly correlated with outcome measures.⁶³ In other words, we can't always assume that a good outcome means a good patient experience.

Many health systems currently use a family of surveys developed by CMS to measure patient experience:

- Consumer Assessment of Healthcare Providers and Systems (CAHPS)
- Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)
- Surgical patients using the Consumer Assessment of Healthcare Providers and Systems (S-CAHPS). The S-CAHPS focuses specifically on preoperative care and care on the day of surgery.
- Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS)
- Consumer Assessment of Healthcare Providers and Systems—Patient Centered Medical Homes (CAHPS - PCMH)

While the CAHPS family of surveys is the most common tool in use, it is worth noting that these surveys emphasize patient satisfaction, which is not completely equivalent to patient experience. Patient experience measurement goes beyond simple ratings of care to focus on the critical and supportive interactions patients would ideally experience during their healthcare encounters.⁶⁴

Data on patient experience for the non-Medicare population is rarely collected at the state level in a usable way. Some exceptions include Minnesota, Massachusetts and Maine.

Patient Experience Case Study (MN):

Minnesota's 2008 Health Reform Law required the Minnesota Department of Health to establish a standardized set of quality measures for healthcare providers across the state. Patient experience of care was a required measure for physician clinics beginning in 2012 and every other year thereafter. All clinics in Minnesota seeing a specific threshold number of unique adult patients during an eligibility period are required to take part in the survey.⁶⁵ In 2016, the state required the Clinician & Group (CG-CAHPS) Survey, which reports experiences of adult patients in four domains: access to care, provider communication, courteous and helpful office staff, and a provider rating.

Patient Experience Case Study (MA):

Massachusetts Health Quality Partners (MHQP) is a nationally recognized, nonprofit coalition of physicians, hospitals, health plans, purchasers, patient and public representatives, academics, and government agencies. MHQP sponsors annual reporting on patient experience. This measurement effort uses the CAHPS-PCMH survey and reflects the experience of adult, commercially insured members of the five largest commercial carriers: BCBS, Fallon Community Health Plan, Harvard Pilgrim Health Care, Health New England and Tufts, representing approximately 80 percent of the state's adult commercially insured population. The state's Center for Health Information and Analysis augments this data with patient satisfaction data from HCAHPS. Both of these results are reported in the state's annual health system performance report and include some demographic data allowing disparities to be examined.⁶⁶

Patient Experience Case Study (ME):

Maine fields a voluntary, statewide survey of patients who received care at healthcare practices using the CG-CAHPS (Clinician and Group) and CAHPS-PCMH (Patient Centered Medical Homes) surveys. The data on healthcare practices are publicly reported, although not aggregated to the state level to track state-wide trends in patient experience.⁶⁷

Conclusion

Decades of steadily rising healthcare prices have led to difficulty affording premiums and higher deductibles, copayments and coinsurance. States play a critical role in ensuring healthcare value for their residents, yet few states are armed with the data that would enable them to comprehensively assess or make improvements to the poor value faced by consumers.

New efforts are needed to assure state residents that their elected officials have taken this problem in hand and are making steady progress towards quality care for a fair price and overall wise use of health system resources.

Timely, complete data are needed to making progress on healthcare value. Data can help advocates and policymakers understand the local reasons for poor healthcare value and confirm whether new methods of provider payment and other cost-containment or quality improvement interventions are working.

This report is a *Call to Action* that details the minimum five domains states should track as part of a commitment to better healthcare value for their residents. It describes the key analyses that should be performed at the state level and provides best-practice examples—proof of concept that accountability is already happening in selected states around the country.

Despite promising efforts in selected states, we find very few comprehensive state-level assessments of healthcare value. Of greatest concerns are:

Spending: Almost no state measures total healthcare spending in their state, either in the aggregate or specific to healthcare services of concern. Given that rapid growth in medical costs harms consumers and strains state budgets, and national studies signal that unwarranted price and utilization variation are likely present in every state, this is a glaring oversight. Equally rare are state goals seeking to constrain healthcare spending growth, yet the work of a few states shows it can be done.

Affordability: The universal absence of state-level affordability standards greatly hinders the ability of states to improve healthcare affordability for consumers. Given that affordability is a top-of-mind concern for consumers, this is another glaring omission. In the interim, states can track indirect measures of affordability like rates of insurance coverage and survey data showing when care was avoided

due to concerns about costs, ideally with the demographic detail to be able to examine disparities.

In light of the well documented consumer harm from unaffordable premiums and out-of-pocket costs for care, states need to standardize how they will measure and make progress on healthcare affordability.

Outcomes: Significant state-level outcomes data—sometimes with detail sufficient to examine disparities—is collected at the federal level and universally available. The task for states is to adopt a common measure set, measured the same way across all payers, and to tightly link outcome measurement to efforts to address healthcare spending and affordability.

Medical Harm: Although estimated to be the third leading cause of death in the U.S., surprisingly little is done to measure, study and address the full spectrum of medical harm that affects the lives of millions of people every year. Minimal data is collected at the federal level, placing the burden on states to set ambitious goals for reductions in all forms medical harm, and a reliable surveillance system to track progress. With the IOM issuing a call to action on this issue in 1999, it is more than past time for states to protect consumers from medical harm. Again, a few states show that it can be done.

Patient Experience: With health system transformation emphasis on patient-centered care, it is critical to capture patient preferences and document the aspects of care that matter most to patients, such as communication skills, respect and courtesy. Tested survey tools for capturing this information have been developed, but it is up to states to deploy them for their non-Medicare, non-hospital patient populations.

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