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

Year	Per Capita Costs of Your Patients
2006	**$4,425**
2005	
2004	

Per Capita Costs of Other Family Practice Specialists in Indiana n = 1,956 Family Practice Specialists		
10th percentile	50th percentile	90th percentile
$1,638	**$3,064**	**$5,169**

Sample Table Segment #2

Service Category	Costs for Your Medicare Patients		Median Costs of All Other Physicians Treating CHF in Indiana
For Professional Evaluation and Management (E&M) Services			
provided by you for your patients in all settings			
Office or Outpatient Visits			
provided by other physicians treating your patients:			
Primary Care Physicians			
For Inpatient Hospital Facility Services			
For Post-Acute Services			
Skilled Nursing Facility			
For Outpatient Hospital Facility Services			
Clinic or Emergency Visit			

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

Key Findings—Degree of Detail

- 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

Conclusions

- **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)**