January 2005

Changes in HEALTH CARE FINANCING & ORGANIZATION

news & progress

Contents

AcademyHealth
Advancing Research, Policy and Practice

AcademyHealth is the national program office for HCFO, an initiative of The Robert Wood Johnson Foundation.

Experts—An Essential Component of the HCFO Program

First authorized in 1989, the Changes in Health Care Financing and Organization (HCFO) program is among The Robert Wood Johnson Foundation's (RWJF) longest running initiatives. One of the hallmarks of the program is its commitment to gathering the input of experts from a variety of disciplines on all program activities. The program seeks expertise regarding grantmaking, publications, and dissemination, as well as meeting development. Expert contributions strengthen the research generated by HCFO grantees and facilitate the transfer of research into policy. From the grant application stage through the dissemination of results, our extensive use of experts ensures that projects will be high quality and will be of use to policymakers.

Application Review

As with any grantmaking program, HCFO's review process and funding determinations are ultimately subjective; however, HCFO incorporates several unique aspects to strengthen the review process. Full proposals that merit funding consideration are evaluated through a rigorous peer-review process, similar to the R01[1] standards used at the National Institutes of Health. However, reviewers are chosen with the project in mind and are experts on the subject matter or methodology proposed. Typically, at least two experts evaluate the merit of a proposal and consider policy relevance, the strength of the methodology, the project's uniqueness, the research team's qualifications, and the appropriateness of the timeline and budget. For fundable projects, the use of experts to evaluate HCFO proposals ensures that submissions receive an objective assessment by individuals who are most familiar with the project's subject matter.

"Judgments about policy relevance are among the toughest," says HCFO Director Anne K. Gauthier. "Reviewers help us understand how the findings will be used and how improvement in the projects could make them even more useful."

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Experts *from page 1*

Applicants who are not selected for funding receive a letter stating the rationale of internal staff and/or expert reviewers for declining the proposal. In instances when HCFO and RWJF staff determine the project does not meet the high standards for funding or does not fall within HCFO's scope, a proposal is not sent for external evaluation. In instances when a proposal has been evaluated externally, blinded reviews may be forwarded to the applicant to assist in conceptualizing future research. Applicants who receive a favorable expert review are also given the blinded reviews and typically receive a detailed list of concerns and questions from the experts that must be addressed prior to a final funding recommendation.

"Judgments about policy relevance are among the toughest. Reviewers help us understand how the findings will be used and how improvement in the projects could make them even more useful."

– Anne K. Gauthier, AcademyHealth

"The process of providing substantive feedback to applicants from the experts is designed to help develop the most policy-relevant and methodologically sound research projects possible," says Deborah Rogal, deputy director of HCFO.

Occasionally, HCFO calls on experts to give post-award advice to applicants as they begin work on their projects. Recently, HCFO awarded funding to researcher Stephen Parente from the University of Minnesota to examine the long-term impact of consumer-driven health plans. HCFO enlisted the help of benefits expert Roland McDevitt from Watson Wyatt to consider whether the most relevant questions were being addressed in the project and if there were ways to expand on or strengthen the analysis as the project moved forward. McDevitt provided direct technical assistance to Parente.

Informing Policy Decisions

HCFO also solicits experts to participate in activities designed to move research findings into the hands of policymakers, plans, or purchasers, sometimes even prior to publication of the results. Program staff may seek out experts who are keyed into the policy arena to assist with a limited distribution of critical findings that may help to inform decision makers. Here, HCFO works with grantees to avoid risking their ability to publish in journals. (See article on prior publication policy at www.hcfo.net/pdf/policy.pdf.)

During HCFO's fall Cyber Seminar, *Consumer-Driven Health Plans: Potential, Pitfalls, and Policy Issues,* Paul Fronstin of the Employee Benefit Research Institute com-

HCFO *NEWS & PROGRESS*

Changes in Health Care Financing and Organization (HCFO) is a national initiative of The Robert Wood Johnson Foundation. This publication is prepared by AcademyHealth, which provides technical assistance and direction for the program. AcademyHealth is the professional home for health services researchers, policy analysts, and practitioners, and a leading, non-partisan resource for the best in health policy.

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plemented the presentation of early research results by Stephen Parente, Meredith Rosenthal, and Judith Hibbard by discussing the implications of the research findings in a "real world" context and offered his informed opinion on the implications of the research for the private market and state and federal policy. He also explored what the research means in the context of increased availability of, and interest in, account-based consumer-driven health plans.

In June 2003, HCFO sponsored a small invitational meeting for a diverse group of experts to discuss the appropriate role of and payment mechanisms for non-visit-based communication. The participants offered insights on whether in the current health care environment, non-visit-based communications should replace or complement traditional physician-patient face-to-face encounters in fee-for-service and capitated practices. The experts at this meeting furthered the debate with their experiences and ideas about how to manage the expansion of various forms of non-visit-based communication between providers and patients, as well as how best to structure payment mechanisms.

Finally, experts make an extremely valuable contribution to the HCFO program through their participation in grantee briefings. These briefings offer grantees an opportunity to present early findings to a policy audience and receive feedback on presentation and policy implications. Recently, Peter Neumann presented findings on the cost-effectiveness, quality, and future of medical technology assessment in Medicare. Researchers, analysts, federal and state policymakers, and health plan representatives commented on the findings. The contribution of experts at these briefings benefits not only the grantee, but all those present.

Clearly, HCFO's prestige and continued success over the past 15 years are due in great part to the contribution of countless experts who offer their wisdom and guidance to staff, grantees, and to the field. ◀

AcademyHealth Releases Ethical Guidelines for Health Services Research

As in all professions, conflicts of interest are inevitable in health services research and health policy analysis. Conflicts can arise when initiating projects, designing study methods, analyzing data, and disseminating research findings, and can involve individuals or organizations. For example, a funder may try to influence a researcher's analysis to ensure an agenda is met, or a researcher might limit the complete disclosure of methods in order to protect intellectual property.

AcademyHealth has issued *Ethical Guidelines for Managing Conflicts of Interest in Health Services Research,* which provides guidance to researchers, sponsors, and others to help them anticipate and manage the inevitable conflicts that will arise in the fields of health services research and policy. It is available at **www.academyhealth.org/pdf/ethicalguidelines.pdf**.

Prior Publication Guidelines for Journal Editors and Authors

Questions about what constitutes previous publication are arising more frequently due to the growth of electronic publishing and the increasing number of reports and papers being produced by organizations and agencies. Active communication among researchers about preliminary findings or the circulation of draft reports for discussion and critique contributes to the eventual quality of published work. In addition, organizations that support or carry out research have an understandable interest in disseminating their work, and policymakers rely on early research findings in the decision-making process.

Many journals will not publish articles that have been published previously. However, the definition of prior publication varied by journal. To help researchers and journal editors preserve the integrity of the publication process and at the same time, facilitate the dissemination of early results, AcademyHealth worked with a group of editors of journals that publish articles on health, health services, and health policy to develop prior publication guidelines. Journals currently using the guidelines include: *Health Affairs; Health Services Research; Inquiry; Journal of Health Politics, Policy and Law; Journal of Health Services Research & Policy; Medical Care;* and *The Milbank Quarterly.*

The guidelines are available at **www.hcfo.net/pdf/policy.pdf.**

1 The Research Project (R01) grant, the original and historically oldest grant mechanism used by NIH, is an award made to support a discrete, specified, circumscribed project to be performed by the named investigator(s) in an area representing the investigator's specific interest and competencies, based on the mission of the NIH. R01s can be investigator-initiated or can be in response to a program announcement or request for application. Universities often use R01 as the standard for "counting" faculty grants toward tenure.

New Grants

What New Are We Buying for the Increased Cost of Health Care?

To what extent are increases in health care costs due to technology?

Health care economists often identify technology as a leading factor in the causes of rising health care spending. Despite the significant role of technology, there is inadequate investment in understanding the most appropriate use of medical technologies and how technology diffuses throughout the health care system.

In a new HCFO-sponsored research project, Jon Gabel and colleagues at the Health Research and Education Trust are undertaking work to lay the foundation for an annual real-time report on changes in the cost of illness and the role of technology in rising health care spending.

"To understand increased health care spending, the first step is to conduct basic 'bean counting'. The goal is to produce intuitively understandable numbers so that policy and opinion makers can grasp how much new and old technologies contribute to the rising cost of health care."

– Jon Gabel, Health Research and Education Trust

During this first phase of the project, the researchers will build a disease-specific database using claims data from a very large national employer for the years 1999 to 2003. They will develop price indices and measure changes in technological service utilization for 20 acute and 10 chronic conditions.

"To understand increased health care spending, the first step is to conduct basic 'bean counting,'" says Gabel. "The goal is to produce intuitively understandable numbers so that policy and opinion makers can grasp how much new and old technologies contribute to the rising cost of health care."

In Phase 2 of the project, the researchers hope to provide decision makers with more detailed information as to what the distribution of this spending is (which services, age groups, types of illness, and geographic areas), both in a cross-section and over time (five years).

"Those findings will be important to public and private decision makers as they will make available basic information as to why health spending is rising, and the painful tradeoffs society faces if it seriously wishes to control health care spending," says Gabel.

One outcome of the study may be suggestions for national tracking systems for technological change that are patient-centered and informed by the diffusion trends identified in these analyses. ◀

For more information, contact Jon Gabel at 202.626.2688.

Market-Level Effects of Medicaid HMOs on Physician Participation, Enrollee Access, and Program Costs

Has managed care led to more office-based physicians serving Medicaid patients?

As states sought to ensure predictable cost increases and improve patient access and quality of care in the 1990s by encouraging enrollment in managed care plans, Medicaid managed care enrollment increased markedly. One goal of Medicaid managed care was to encourage enrollees to seek care in private physician practices rather than emergency rooms, and thereby increase access to medical care and reduce the use of more costly services. While managed care appeared to improve certain aspects of access in some geographic areas, previous research results have not demonstrated whether the growth of Medicaid health maintenance organizations (HMOs) has led to a shift in service use that is inherently cost-saving.

In a new research project at Emory University, Bradley Herring, Ph.D., and colleagues will examine the effect of increased use of capitated Medicaid HMOs on participation by office-based physicians. They will then examine the effect that this form of delivery system has on the use of different types of services by Medicaid enrollees in the same market area and whether changes in service use appear to be cost-saving.

According to Herring, rising medical costs and state fiscal stress make this a critical time to consider the effects of Medicaid managed care and better understand what it "buys" for states. Having more office-based physicians who are willing to accept new Medicaid patients can increase patients' access to medical care by reducing waiting times, travel times, etc.

"This increased access to care has the potential also to reduce costs in two major ways," says Herring. "First, it could shift costly emergency room visits to a less expensive site for care, and second, it could increase access to early preventive care in order to reduce costly procedures in the future."

"Rising medical costs and state fiscal stress make this a critical time to consider the effects of Medicaid managed care and better understand what it 'buys' for states."

– Bradley Herring, Emory University

The researchers will use data from the Community Tracking Study's Physician and Household Surveys to examine these issues in a multivariate context in and across multiple geographic regions. Their findings will help policymakers determine whether they should encourage the use of Medicaid HMOs or perhaps scale back on their use. For example, Tennessee officials are currently considering transforming their TennCare managed care program back to a traditional Medicaid program, while Georgia intends to contract with HMOs to provide services to their Medicaid population.

"Our analysis will shed light on whether these are good decisions with respect to the impact on program costs and enrollee access to care," concludes Herring. ◀

For more information, contact Bradley Herring, Ph.D., at bjherri@sph.emory.edu.

Use of Tiered Networks by Employer-Sponsored Health Plans

What is the current or planned use of tiered hospital and physician networks in employer-sponsored health plans?

Economists and policymakers have contended for years that health care costs might be reduced and quality improved through the use of appropriate financial incentives, but the search for the "right" incentive seems never-ending. As one of the latest strategies, health plans have begun to implement differential payments for distinct groupings, or "tiers" of providers, to entice enrollees to choose certain hospitals and/or physicians over others. The "tiers" are determined based on cost and quality factors, typically requiring enrollees to pay higher co-payments if they choose to receive care at a more expensive or lower quality hospital.

For some time, health plans have used tiered payments for their pharmacy programs, but little is known about how similar incentives will work for physicians and hospital benefits.

William Thomas, Ph.D., of the University of Southern Maine will examine tiered network design and implementation, health plan marketing and enrollment, and market responses (both employer and provider) to tiered networks. In particular, Thomas and his colleagues will study the extent to which such networks exist and the factors leading to their development, as well as how the tiers are determined and whether specific services, physician specialists, or hospitals are excluded.

"It is important to understand the history and structure of these arrangements, the response to them, and their effect on access and quality," says Thomas.

"Tiered networks are intended to promote consumer sensitivity to cost and quality differences among providers. If found effective at achieving this objective, tiered networks are likely to be adopted widely throughout the U.S., especially in larger health care markets."

– William Thomas, University of Southern Maine

The researchers will gather information through a survey of 2,900 employer-sponsored health plans about their current or planned use of tiered hospital and physician networks. They will append structured questions to the 2005 and 2006 versions of the National Survey of Employer-Sponsored Health Plans, fielded annually by Mercer Human Resources Consulting. Personal interviews and focus groups also will be conducted in five case study sites identified through analysis of the 2005 survey responses.

"Tiered networks are intended to promote consumer sensitivity to cost and quality differences among providers," says Thomas. "If found effective at achieving this objective, tiered networks are likely to be adopted widely throughout the U.S., especially in larger health care markets." ◀

For more information, contact William Thomas, Ph.D., at 207.529.2009.

The Challenges of Health Care Rationing

Is rationing inevitable if health care costs continue to rise?

Twenty years ago, in *The Painful Prescription: Rationing Hospital Care,* Henry J. Aaron, Ph.D., and William B. Schwartz, Ph.D., explored the implications of health care rationing. This seminal work compared the use of several advanced medical technologies in the United States and Great Britain, reported sizeable differences in several technologies, and explored the reasons why the British rationed some but not all services severely. Given limitless demand and continued spending growth, the authors anticipated that the United States would eventually need to ration health care.

A new project will revisit this subject with the benefit of two additional decades of experience in both countries and largely new data. It will result in a book-length manuscript due to be published in mid-2005, and two policy briefs. Aaron also plans to gather data comparing use of pharmaceutical products in the United States and Great Britain.

In the 1980s, government forecasters predicted that health care spending, if not limited, would approach 20 percent of gross domestic product by the end of the century. In the 1990s, health care spending slowed, and pressures to ration abated. According to Aaron, experts now anticipate rapid spending growth over the coming decade and beyond, with no knowledge of when rising costs will become intolerable.

"The goal is to clarify the choices that will result if that 'external constraint' known as rationing forces patients to forgo care and to explore what institutional changes will be required to make rationing sustainable," Aaron says. ◀

For more information, contact Henry Aaron, Ph.D., at 202.797.6128.

Hospital Ownership and Performance

How does ownership affect hospital quality, cost, or provision of uncompensated care?

Despite numerous studies to date, questions remain about whether hospital ownership affects institutional performance on dimensions such as cost, quality, or care for the uninsured. In a new HCFO-sponsored study, Karen Eggleston, Ph.D., from Tufts University, and Yu-Chu Shen, Ph.D., from the Naval Postgraduate School, are synthesizing the main findings of existing literature on hospital ownership and performance between 1990 and 2004. Specifically, the researchers are using meta-analysis and meta-regression to summarize the extent to which ownership matters for different dimensions of hospital performance, and to examine what study characteristics help to account for conflicting findings. Since ownership conversions do not occur randomly among hospitals, and for-profits do not randomly enter markets, the researchers are paying special attention to how studies account for market interaction and selection bias.

"Findings from our meta-analysis of the hospital ownership literature will contribute to productive, evidence-based debate on a wide range of policies, such as setting provider payment and evaluating for-profit conversions in health care markets," says Shen. ◀

For more information, contact Karen Eggleston, Ph.D., at karen.eggleston@tufts.edu.

Is the Impact of Managed Care on Hospital Prices Decreasing?

How do changing supply and demand conditions affect prices for the inpatient services of privately insured patients?

One of the tenets of effective managed care is that health plans must be able to undertake selective contracting. To do so, plans must have a choice among providers that permits competition, as well as the ability to provide incentives for patients to use designated providers. Following the introduction of widespread managed care, growth in health care spending slowed. Recently, however, expenditure growth has accelerated.

William D. White, Ph.D., at Cornell University and colleagues are examining two possible explanations for the recent upsurge in health care spending, despite the widespread adoption of managed care: 1) On the supply side of the market, downsizing and provider consolidation have led to increased market concentration; and 2) On the demand side, relaxation of plans' constraints on consumers' choices of providers have reduced plans' ability to steer patients and negotiate significant discounts.

"Either of these phenomena might lead to increased prices," White notes. "However, the policy implications and recommendations would be quite different, so it is important to disentangle their role."

The researchers will update findings on the effects of provider consolidation, test the relationship between consumer choice and price, and provide a basis for considering the degree to which changes in supply and demand in hospital markets have contributed to price increases. Using data from California and Florida, White and colleagues will test a series of hypotheses regarding the effects of changes in hospital concentration and price sensitivity. In particular, they will ask: 1) What would happen to prices in more recent periods if measures of concentration and/or factors associated with price sensitivity were held fixed at previous levels? and 2) Have the magnitudes of coefficients associated with these variables changed?

They will use regression analysis and pooled cross-section time series data drawn from state and American Hospital Association data files, the Area Resource File, and unique data on managed care organization network size. For each state, they will compare three time periods—a base year after the initial growth of managed care, but early in the process of consolidation; a year in the mid-1990s as the shift began toward reduced plan restrictions on consumer choice; and the most recent year for which data are available.

"Comprehending the factors driving hospital prices is critical. Understanding the extent to which they are driven by demand versus supply factors is vital for developing appropriate policy and financial incentives for controlling health care spending."

– William D. White, Cornell University

Much research about managed care and its impact exists. However, current trends in expenditures are difficult to evaluate and while anecdotes abound, solid evidence is critical for future policy. "Comprehending the factors driving hospital prices is critical," says White. "Understanding the extent to which they are driven by demand versus supply factors is vital for developing appropriate policy and financial incentives for controlling health care spending." ◀

For more information, contact William D. White, Ph.D., at 607.254.6476.

The Effect of Hospital Mergers on HMO Hospital Costs and Premiums, 1990–2001

To what extent is hospital consolidation responsible for the resurgence of health care inflation in the late 1990s?

In the mid-1990s, health care costs and accompanying health insurance premiums stabilized. Some proponents attributed this to the rise in managed care and its controls, including increased power over providers and utilization management. However, in the late 1990s, health care costs rose again while hospitals across the nation consolidated into local, regional, and national hospital systems. At least part of the increases in hospital costs may be a result of hospital consolidations and the hospitals' new negotiating power with managed care organizations. Anecdotal evidence suggests that an increasing number of hospital mergers has reduced competition in the market.

New research at the University of Minnesota will determine the joint effects of managed care and hospital mergers on costs and premiums. Robert Town, Ph.D., and colleagues are examining the degree to which hospital consolidation has increased what health maintenance organizations (HMOs) pay for hospital care and the resulting effect on premiums, as well as how much hospital consolidation was related to HMO consolidation.

A key component of the study is the linking of two datasets on HMOs and hospitals from 1990 to 2001. The linked data will allow the research team to explore market evolution during this time period as well as the rates of hospital consolidation, hospital per diem charges, and premium increases.

"While integrated delivery systems do not appear to have been successful in integrating service delivery, some evidence suggests that they have been somewhat successful in accomplishing horizontal hospital consolidation. That could have anti-competitive effects if it facilitates horizontal collusion or increases hospital power," says Town.

This information is vital to the Federal Trade Commission and the U.S. Department of Justice because they are examining the consolidations as part of new antitrust enforcement efforts.

"While integrated delivery systems do not appear to have been successful in integrating service delivery, some evidence suggests that they have been somewhat successful in accomplishing horizontal hospital consolidation. That could have anti-competitive effects if it facilitates horizontal collusion or increases hospital power."

– Robert Town, University of Minnesota

"If we find that hospital consolidation affects the prices HMOs pay to hospitals and the premiums they charge, we will be able to identify the specific types of markets that are at greatest risk of adverse, anti-competitive effects from hospital consolidation," says Town. ◀

For more information, contact Robert Town, Ph.D., at rjtown@umn.edu.

Impact of Benefit Reduction and Increased Cost Sharing in a Medicaid Program

How have benefit reductions and increased cost sharing affected the Oregon Health Plan?

With a shortfall of $2 billion in fiscal year 2004 and an estimated $1 billion in 2005, Oregon has turned to cost sharing and benefit reduction in its Medicaid program, the Oregon Health Plan (OHP). While there is research documenting the cost of providing care to the uninsured and assessing the impact of Medicaid expansions, few studies examine the impacts of benefit reductions on access, utilization, and quality of care for Medicaid enrollees.

Jeanene Smith, M.D., M.P.H., and colleagues from the Office for Oregon Health Policy and Research, will work with investigators from Portland State University and the Oregon Health and Science University to examine the impact of Oregon's cost sharing and benefit reductions as key cost-containment strategies. "An examination of the impact of such policy decisions is vital to all states as they are forced to make similar decisions," says Smith.

Concerned about the potential deterioration of access to health care, the Office for Oregon Health Policy, the Medicaid program, and the Office of Medical Assistance Programs (OMAP) formed the Oregon Health Research and Evaluation Collaborative (OHREC) in December of 2002. This statewide organization of health services researchers from Oregon's universities and health systems works closely with state and local agencies. The collaborative is studying the impact of Medicaid cutbacks on low-income Oregonians' access to health care and on how that research will be translated back to the policymakers. Several pilot studies have been completed, including an analysis of the impact on premiums on OHP enrollment and a survey of those who have disenrolled from the OHP.

"The individual results and synthesis of this project will inform policy and contribute to our national understanding of the complex interactions between cost-sharing increases, benefit reductions, and individual behavior during difficult economic times."

– Jeanene Smith, Office for Oregon Health Policy and Research

Smith and colleagues' examination will build on those preliminary studies through two projects: The first will address the economics of benefit design by examining cost shifts within OHP, while the second will compare utilization of emergency departments (EDs) across the state before and after the changes in the OHP. This examination will focus particularly on changes in admissions for ambulatory care sensitive conditions as well as ED admissions for behavioral health diagnoses.

"Overall, the individual results and synthesis of this project will inform policy and contribute to our national understanding of the complex interactions between cost-sharing increases, benefit reductions, and individual behavior during difficult economic times," says Smith. ◀

For more information, contact Jeanene Smith, M.D., M.P.H., at 503.378.2422, ext. 420, or jeanene.smith@state.or.us.

The Impact of Multiple Consumer-Driven Health Plans Beyond Early Adoption

As experience builds, what does the evidence show?

Since 2001, consumer-driven health plans (CDHPs) have evolved from a specialized niche for large self-insured employers to a mainstream alternative to traditional health insurance, with many *Fortune* 500 firms now offering them. Established insurers such as Blue Cross Blue Shield, Aetna, and UnitedHealth Group are offering CDHPs to compete against CDHP start-up companies such as Definity Health, Lumenos, Vivius, and Health Market.

In a new project at the University of Minnesota, Stephen Parente, Ph.D., and colleagues are building on previous work and examining the longer term impact of CDHPs. In particular, they are evaluating the plans' impact on quality of care, as well as cost and utilization, and variation on these outcomes by different CDHP designs, including health savings accounts (HSAs).

Using six years of claims and employer datasets from firms and multiple CDHP insurers, the researchers will address four research questions:

1) What is the long-term effect of CDHPs on health care cost and use?
2) Are the newly legislated HSAs producing different results from other CDHPs?
3) What is the quality of care for CDHP enrollees with chronic illnesses such as diabetes and heart disease? and
4) How do consumers manage their CDHP spending accounts over time?

"Accurately evaluating a fluid and evolving market such as a CDHP is a complex task. But answering these questions can inform the design of an ideal CDHP."
– Stephen Parente, University of Minnesota

"Accurately evaluating a fluid and evolving market such as a CDHP is a complex task," says Parente, "but answering these questions can inform the design of an ideal CDHP." ◀

For more information, contact Stephen Parente, Ph.D., at sparente@csom.umn.edu.

New Findings Briefs Available from HCFO

Evaluating Promising New Treatments for Life-Threatening Disease: Implications of the HDC/ABMT Experience for Treating Breast Cancer, January 2005
For diseases such as breast cancer, a tension frequently exists between the desire of patients and physicians to have access to potentially beneficial treatments as soon as possible and the often lengthy requirements of randomized clinical trials (RCTs). A research team led by Richard Rettig, Ph.D., of RAND examined how and why HDC/ABMT for treating breast cancer diffused widely before its effectiveness was established, how and why technology assessments failed to slow diffusion, and how and why RCTs were finally completed and decisively stopped diffusion.

Learn more at **www.hcfo.net/pdf/findings0105.pdf**.

Managed Care Does Not Appear to Have a Spillover Effect on the Quality of Diabetes Care for Medicare Patients, December 2004
Research and policy experts often assume that growth in the market penetration of managed care organizations has changed health care market behavior across the board. However, according to new research at the Mount Sinai School of Medicine sponsored by HCFO, there is little evidence to suggest a spillover effect of managed care market penetration on individuals with diabetes in the non-managed care sector, specifically Medicare beneficiaries with diabetes enrolled in fee-for-service plans.

Read more about the project at **www.hcfo.net/pdf/findings1204.pdf**.

New Approaches to Identifying Market Power in Health Care

What is the best tool for determining whether a hospital merger is anticompetitive?

Hospital consolidation—at least according to the prevailing wisdom—wrings excess capacity from the health care system, fosters efficiency, and creates savings. In some cases, however, hospital mergers have an anticompetitive effect that ultimately drives up health care costs. Antitrust enforcement hinges in large part on defining the relative geographic market in which hospitals compete. If a change in market concentration is substantial, a merger may be anticompetitive. Courts rely on an analytic tool called the Elzinga and Hogarty approach, developed 30 years ago, to define geographic markets.

A new research project led by David Dranove, Ph.D., and colleagues at Northwestern University will validate and disseminate a very different analytical model called the "willingness-to-pay (WTP) approach" to assess market power and the potential anticompetitive effect of hospital mergers. They will examine whether the WTP approach is sound and should therefore replace the current Elzinga and Hogarty method, which the researchers and others believe is outmoded and theoretically unsound.

In a recently released report, *Improving Health Care: A Dose of Competition,* the Federal Trade Commission and the Department of Justice noted that hospital markets need to be defined properly and encouraged research to validate or refute the existing analytical techniques for defining geographic markets.

"Our study directly responds to the agencies' call for research," says Dranove. "We believe that the implementation of a new model for measuring antitrust markets will ensure that the competitive approach to health care delivery has a reasonable chance of succeeding."

"We believe that the implementation of a new model for measuring antitrust markets will ensure that the competitive approach to health care delivery has a reasonable chance of succeeding."
– David Dranove, Northwestern University

The WTP approach uses patient-level hospitalization data to estimate the value that a hospital brings to a managed care network. WTP is high when a hospital offers valued services or has an attractive location, but is reduced when there are attractive competing hospitals. Mergers eliminate that competition, increase WTP, and, in theory, permit price increases. This study will validate the use of WTP to measure whether mergers facilitate price increases, thus providing exactly the kind of alternative to Elzinga and Hogarty required by the courts. ◀

For more information, contact David Dranove, Ph.D., at 847.491.8682.

New Resource on Health Outcomes Now Available

AcademyHealth has produced a core list of books, journals, Web sites, and bibliographic databases for the field of health outcomes. Developed under contract with the National Library of Medicine, the Health Outcomes Core Library Module Project serves as a guide for those new to the field or those interested in developing a collection of resources in health outcomes.

Check it out at **www.academyhealth.org/publications/healthoutcomes.htm.**

Improving Access to Improve Quality: Evaluation of an Organizational Innovation

Can quality be improved by creating patient-centered delivery systems?

In 1999's *Crossing the Quality Chasm,* the Institute of Medicine (IOM) concluded that the U.S. health care system is plagued by low quality and argues that poorly designed delivery systems are a major cause of the problem. The IOM suggests that quality can be improved partly by creating patient-centered delivery systems offering continuous access to health care.

Group Health Cooperative (GHC), a health maintenance organization (HMO) in Washington state, has launched an initiative to improve quality by increasing enrollee access to physicians and information. David Grembowski, Ph.D., is leading a team of investigators at the University of Washington and the Group Health Cooperative's Center for Health Studies to evaluate the initiative, which is composed of the following six patient-centered changes in the GHC delivery system:

1) same-day appointments with primary and specialist physicians;
2) direct patient access to specialist physicians (removal of gatekeeping);
3) patient-physician e-mail messaging (with physician compensation for responding to patient e-mails);
4) physician compensation with productivity and quality incentives;
5) enrollees having Internet access to their GHC electronic medical records; and
6) health promotion information on the GHC Web site.

The researchers will use Group Health's automated databases, member and physician satisfaction surveys, patient visit surveys, and in-depth interviews with care providers to better understand the impact of new information technology and payment incentives on patient and provider health care decisions and utilization. Based on these data, they will determine how the access initiative is affecting cost, utilization of services, quality of care, member enrollment, and patient and provider satisfaction.

Improving access on a population level by reducing system barriers can yield quality and health benefits that far outweigh health benefits incurred by improving patient safety alone.

The highly innovative interventions to improve access and quality of care that GHC has developed provide a model for both private and public plans seeking to improve their delivery systems.

"To receive quality care, people must have access to care," says Grembowski. Improving access on a population level by reducing system barriers can yield quality and health benefits that far outweigh health benefits incurred by improving patient safety alone. He continues, "As an integrated group practice, GHC is a good case study for policy development." ◀

For more information, contact David Grembowski, Ph.D., at 206.616.2921.

Medicaid and Young Adults in the Military

What is the likelihood that enlistees have been enrolled in Medicaid during their childhood and adolescence?

Little is known about the relationship between Medicaid and today's recruits into an all-volunteer military. Historically, however, Medicaid's child health component, the Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT), grew in significant part out of a landmark Selective Service study focused on the health status of young draftees rejected for military service.[1] In addition, today's recruits, who disproportionately tend to be from lower income households, came of age during the Medicaid childhood coverage expansions of the 1980s and 1990s, which resulted in a significant increase in the number of low-income children enrolled in Medicaid.

Sara Rosenbaum, J.D., and colleagues at George Washington University are examining the relationship between Medicaid and the young adults (and their families) who serve in the military. "This relationship is important," says Rosenbaum. "Young recruits may well have relied on Medicaid as part of the range of public programs that represent social investments in the very children who someday will be called on to serve the nation." Furthermore, because young military families have low incomes, says Rosenbaum, they may rely heavily on Medicaid, particularly if they have children with special needs.

The researchers will synthesize available information about the economic status of members of the military during their pre-enlistment lives. They will include results of other studies that considered the use of public programs by military families. In addition, the investigators will examine what is known about the health status and pre-enlistment coverage arrangements of new enlistees, and the health coverage arrangements for military families with children. Finally, the researchers will explore the experience of Medicaid programs in states that have a strong presence of military families.

Using data from the Health Care Survey of Department of Defense Beneficiaries and the Defense Enrollment Eligibility System, supplemented by qualitative studies and interviews with experts in military health care, the researchers will examine the health status patterns of new entrants by payer source; how extensively 12-months prior Medicaid enrollment is represented among new enlistees compared to the age cohort of young adults as a whole; and the probability that young enlistees were enrolled in Medicaid at some point during childhood or adolescence. Through interviews, they will also identify common experiences of communities surrounding five-to-seven of the largest military bases in terms of health care needs, Medicaid enrollment, and utilization.

"When a program for low-income children and adolescents reaches so great a level of penetration, its relationship to their later lives takes on special interest," says Rosenbaum. "This is particularly true in the case of the military." Better understanding this relationship can inform the policy debate regarding Medicaid budgets and program design. ◀

For more information, contact Sara Rosenbaum, J.D., at 202.530.2303.

1 B. Karpinos, 1966. Office of the Surgeon General, Department of the Army, cited in Maternal and Child Health Care Programs, *Office of the Assistant Secretary for Program Coordination, HEW, Washington, D.C. 1966.*

Modeling the Decisions of Medicare Health Plans

Will regional competitive bidding work?

While the inclusion of a prescription drug benefit under the Medicare Modernization Act (MMA) offers significant advantages for beneficiaries, access to drugs depends significantly on the availability of health plans offering the benefit. Under the MMA, plans submit competitive bids for the cost of providing the drug benefit in a particular service area.

While competition is generally considered a good way to encourage efficiency, improve geographic equity, and provide better value for money, private, risk-bearing health plans may not find the bidding process advantageous enough to induce them to service some parts of the country. A new research project led by Steven Pizer, Ph.D., and colleagues at the Boston University School of Public Health will examine the market entry and exit behavior of health plans (health maintenance organizations (HMOs) and preferred provider organizations (PPOs)) in the Medicare program.

The researchers are determining whether health plans offering a drug benefit will require higher premiums or more extensive risk sharing to induce them to enter counties or regions with low population densities. They will also examine the factors that influence individuals' choices among plans to determine whether competition between regional PPOs and local HMOs may exacerbate adverse selection and cause instability in plan premiums and participation.

The researchers note that the market entry decisions of private plans may determine whether Medicare outpatient prescription drug coverage will be available throughout the country, particularly in rural areas. Their goal is to generate information of use to policymakers seeking to encourage private plan participation in Medicare. Because of the size of the program, says Pizer, weaknesses in design can quickly bust the federal budget or cause premiums to become unaffordable, leading to disruptions in coverage for an enormous number of beneficiaries.

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Four attempts in the late 1990s to implement a demonstration of competitive pricing in Medicare proved unsuccessful. Thus, the Medicare program has no experience with bidding among health plans. Pizer's project will help policymakers evaluate the success and value of the competitive bidding process.

"With such sweeping legislation, there are bound to be unintended consequences," says Pizer. "We hope that our research will be able to foresee some of these before they become genuine crises." ◀

For more information, contact Steven Pizer, Ph.D., at 617.232.9500, ext. 6061.

Consumer-Driven Health Plans and Consumer Behavior

Will consumers engage as proponents would expect?

A key component of consumer-driven health plans (CDHPs) is, as the name suggests, consumer involvement. The approach is based on the premise that providing more information, along with financial incentives, will result in consumers becoming more active in choosing providers and treatments. However, it is not clear whether the financial incentives and information tools inherent in the CDHPs will be sufficient to stimulate this level of change in consumers, according to Judith Hibbard, Ph.D., at the University of Oregon.

"This study allows us to examine the degree to which reductions in costs and utilization within consumer-driven plans can be attributed to changes in consumer engagement and informed consumer choices or to selection bias."

– Judith Hibbard, University of Oregon

"This approach implies that consumers will accept a higher level of responsibility and possess the knowledge, skills, and confidence to make meaningful changes in their health care," says Hibbard.

Despite the vast policy and market interest in consumer-driven plans, little is known about the decision-making experiences of enrollees over time, nor which financial incentives and information best influence prudent health care decisions.

Hibbard and colleagues are working with Definity Health Plan and the Whirlpool Corporation, which offers employees the Definity consumer-driven plan or a more conventional PPO health plan, to explore the validity of assumptions about consumer behavior underlying consumer-driven health plans. The researchers are tracking a cohort of employees enrolled in Definity and another cohort enrolled in a traditional preferred provider organization (PPO) option. They are collecting baseline survey data and claims data for a period of 24 months on both groups of employees.

By using both qualitative and quantitative methods and a longitudinal cohort design, the researchers are able to compare the knowledge, use of information, satisfaction with care, cost-effective utilization, and cost of care for persons enrolled in Definity and the PPO over time. In addition, they are examining the effects of financial incentives and information on health care decisions and related costs for Definity enrollees.

"This study allows us to examine the degree to which reductions in costs and utilization within consumer-driven plans can be attributed to changes in consumer engagement and informed consumer choices or to selection bias," says Hibbard.

If the findings indicate that cost savings can be attributed to more informed consumer choices, the researchers can assess the factors that contribute to increased consumer activation. Thus, the results will provide insight into the value of pursuing the consumer-driven approach, as well as inform possible strategies for boosting the efficacy of the approach. ◀

For more information, contact Judith Hibbard, Ph.D., at jhibbard@uoregon.edu.

Patient-Reported Quality Information

Can it be used to improve quality and choice?

Increasingly, consumers and purchasers are demanding quality performance information so that they can make appropriate decisions about choosing providers. In addition, many payers are considering whether to tie a portion of provider payment to performance. However, there are a number of obstacles that must be overcome before performance measurement and reporting can be widely used and made available. Two major barriers are opposition from providers and the high cost of measurement and reporting activities.

In a new research project at the Pacific Business Group on Health, Ted von Glahn and colleagues will examine whether the same patient-reported performance information could be used for patient selection of doctors, quality improvement activity conducted by group practices, and pay-for-performance activities. The researchers believe that using the same data for all three purposes could increase the acceptance of reporting and reduce the costs of data collection. They will test these hypotheses at a California group practice, where patient-reported performance scores are already linked to financial reimbursement levels in a health maintenance organization (HMO) plan.

The researchers will collect data from a short-form version of the Ambulatory Care Experience Survey (ACES) and will use it to report back to the group practices and in a consumer-choice decision-support tool. They will assess whether there is a relationship between patients' choice of physician and those physicians' patient-reported quality performance measures. They'll also assess whether group practices use this information to improve care.

"We want to overcome professional opposition by demonstrating the value of this information to medical groups and documenting its importance to consumers who are making real-life doctor choices," says von Glahn. In addition, the adoption of a standard survey instrument to achieve multiple outcomes could help to lower the costs of data collection.

"The strategy for public reporting of physician performance should be rooted in performance information that has been demonstrated to be of value to providers and plans in quality incentive programs and of value to consumers in making decisions."

– Ted von Glahn, Pacific Business Group on Health

"The strategy for public reporting of physician performance should be rooted in performance information that has been demonstrated to be of value to providers and plans in quality incentive programs and of value to consumers in making decisions," says von Glahn. This work will contribute evidence about the value of patient-reported information in that strategy. ◀

For more information, contact Ted von Glahn at tvonglahn@pbgh.org.

AcademyHealth News

HCFO team members also work on other AcademyHealth projects designed to ensure that research results are useful to decision makers. We report below on several key projects of interest to our readers.

AcademyHealth Partners with The Commonwealth Fund and RWJF to Examine Administrative Simplification in Health Care

In December 2004, The Commonwealth Fund awarded a grant to AcademyHealth through which the two organizations will collaborate on a research and case study project to understand better ways to promote administrative simplification in health care. The research component of the project is a collaboration with the HCFO program; Commonwealth, RWJF and AcademyHealth HCFO staff will jointly solicit proposals aimed at quantifying the administrative burden on the health care system and exploring potential remedies. Through the Commonwealth grant, the HCFO team will also develop and guide case studies that offer interesting examples of a variety of administrative issues—including those that have used creative methods to resolve administrative burdens, or those at which efforts to create administrative simplification have not been successful.

For more information on this project, contact Bonnie Austin at 202.292.6700.

AcademyHealth Facilitates CMS Meeting on Chronic Care for Medicare Beneficiaries

Increasingly, Medicare beneficiaries are challenged by multiple chronic conditions, such as congestive heart failure or other heart disease, diabetes, or osteoarthritis. However, the current health care delivery system is primarily structured and financed to manage a series of acute conditions in discrete settings.

In July, AcademyHealth, with the National Academy of Social Insurance, facilitated a meeting with researchers, health plan officials, and clinicians to identify strategies that Medicare could adopt to improve care for chronically ill beneficiaries. Meeting participants also set research priorities and discussed data requirements. The Centers for Medicare and Medicaid Services sponsored the program, which will inform their efforts to develop a research and data strategy to improve care for the chronically ill, as mandated by the Medicare Modernization Act.

"Developing risk stratification methods for Medicare beneficiaries with chronic conditions and implementing them are high priorities," according to Anne Gauthier, vice president of AcademyHealth. Participants were sensitive to resource constraints, and encouraged use of risk stratification as a way to focus resources where they might have the greatest impact in improving health care. Providers also need to have more information about their patients, including utilization history and information about other providers seen.

Finally, participants encouraged a longitudinal view of patient care. They believed that a focus on care over time for individuals, not just on patterns of care across settings, would facilitate better quality health care.

For more information about the meeting, contact Sharon Arnold at 202.292.6700.

Update on Research Syntheses

Frequently, a significant gap divides the academic and policy communities. It exists, at least in part, because academic researchers and policymakers communicate differently and are separated by different incentives and value systems. Bridging this gap is important to the pursuit of evidence-based policy decision-making and is at the heart of three projects funded by the Agency for Healthcare Research and Quality (AHRQ).

In the first, jointly funded by HCFO, AcademyHealth convened experts in January 2004 to identify pressing policy questions on the future of Medicare. The final report, submitted to AHRQ in September, includes scopes of work for syntheses on: benefit design and cost sharing; markets and private plans; financial and non-financial incentives for quality; and beneficiary education and information.

In two other synthesis projects, AcademyHealth is working with subject matter experts to draft technical syntheses and policy briefs on: 1) Medicare and prescription drugs, and 2) employer responses to health insurance inflation. Jack Hoadley of Georgetown University is writing the technical synthesis for the first project, and Bryan Dowd of the University of Minnesota is writing the synthesis of the second.

For more information on the synthesis projects, contact Sharon Arnold at 202.292.6700.

Promises and Pitfalls of Web Publishing for Health Services Research

The Internet has forever changed the way people exchange written materials, ideas, and information. By enabling broader and faster exchanges of research findings and scholarly papers than are possible with printed media, the Web is altering the kinds of products that users expect and that researchers and publishers will create.

Realizing that changes in product type and distribution are affecting the underlying business model of some traditional publications, especially relatively low-volume, academic journals, the Agency for Healthcare Research and Quality (AHRQ) sponsored an expert meeting conducted by AcademyHealth in November to give journal publishers and editors, foundations, and others a chance to discuss the challenges facing health services research journals in the new Web environment.

"AHRQ realizes that the journals most involved with the field of health services research are at a crossroads regarding use of the Internet," says Dan Campion, AcademyHealth's project director for AHRQ's Knowledge Transfer initiative. "The Agency developed this expert meeting to explore these issues."

Discussions at the meeting focused on trends in professional health care publishing, current business models used by health services research journals, and stakeholder perspectives on issues such as: 1) How do researchers/academics view and adapt to Web publishing? 2) How do end-users/decision makers and librarians make best use of Web publishing? 3) How can public and private funders of health services research facilitate a transition to Web publishing?

A report is forthcoming.

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Transforming Health Systems through Leadership, Design, and Incentives

A growing body of research has documented sizeable problems in health care quality, safety, and efficiency. There is also considerable agreement that addressing this problem will require not only improved information technology, but also a broader transformation in the way we organize and pay for care.

On October 18–19, the Agency for Healthcare Research and Quality, the Centers for Medicare and Medicaid Services, the National Cancer Institute, and *Health Affairs* sponsored a meeting of experts to explore ways to organize systems and incentives to foster quality, efficiency, appropriate clinical processes, culturally and ethnically sensitive care, and shared decision-making. HCFO Senior Research Manager Sharon Arnold facilitated the meeting.

Participants identified a number of activities that they felt deserved support. These included activities focused around dissemination, implementation, measurement, payment policy changes, and basic research. Findings from the meeting will inform the design of the Medicare Health Quality Demonstration, which was mandated in Section 646 of the Medicare Prescription Drug, Improvement and Modernization Act.

For more information on the meeting, contact Sharon Arnold at 202.292.6700.

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