

TRANSFORMING HEALTH CARE

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TRANSFORMING HEALTH CARE: A FOCUS ON CONSUMERISM AND PROFITABILITY

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INTRODUCTION

The Patient Protection and Affordable Care Act (ACA) included changes in health care reimbursement and incentive mechanisms and enhanced public reporting of patient outcomes, patient experience, and Medicare spending per beneficiary. The goal was to radically transform health care organizations by increasing accountability for key performance domains. While what constitutes a fair assessment of performance might be controversial at times, there is an agreement that the health care system, led by the federal government as a dominant payer, needs to solidify the structures and mechanisms that herd health care organizations toward the desired performance goal of delivering cheaper, patient-centered, effective, and error-free care (Al-Amin, Makarem, & Rosko, 2016; Ryan, Krinsky, Maurer, & Dimick, 2017). Two prominent mechanisms include new value-driven reimbursement models and public reporting to increase transparency and inform consumer choice. In this volume, we focus on these mechanisms and on their implications.

Two key stakeholders, simultaneously impacted the most by the goal of high performance and essential for its successful attainment, are health care organizations and consumers. Both stakeholder groups must be equipped with the right tools and incentives to competently play their part in the optimal coproduction of health care services. Health care organizations are incentivized to commit to the goal through constantly evolving reimbursement models such as bundled payments and value-based purchasing (VBP) programs. Public reporting and price transparency, on the other hand, aim at encouraging patient engagement and consumerism in health care by facilitating consumer selection of health care providers with the best performance.

Health care organizations need access to sufficient resources to successfully transform their processes and culture in such a way that ensures better performance. Health care organizations are businesses, and regardless of their ownership status, they need to generate profit in order to sustain their operations, to acquire essential and strategic resources, and to achieve their mission by contributing to their communities (Bazzoli, Chan, Shortell, & D'Aunno, 2000). Factors such as ownership, size, occupancy rates, and advanced technologies are associated with higher profitability (Burkhardt & Wheeler, 2013; Rosko, Goddard, Al-Amin, & Tavakoli, 2018). Further understanding of the factors that influence hospital profitability is imperative as hospitals struggle to achieve their financial goals.

Consumers, despite the abundance of publicly reported data in the United States, are either unaware of data availability or do not rely on publicly reported data to select providers (Sinaiko, Eastman, & Rosenthal, 2012). Transparency in

quality, patient experiences, and prices is essential for consumerism to work in health care. However, transparency of data alone, while a baseline requirement, is not sufficient. Consumers have to be aware of what data are available, convinced of their usefulness and applicability, and able to interpret the data when they make health care related choices. Carman, Lawrence, and Siegel (2019) explain consumerism as “people proactively using trustworthy, relevant information and appropriate technology to make better-informed decisions about their health care options in the broadest sense, both within and outside the clinical setting.” Given that transparency in patient outcomes, experiences, and prices is a new shift in the health care industry, it is essential for us to understand what true transparency means and how to optimally use this transparency of data to improve consumer decisions to achieve the desired performance goal of delivering cheaper, patient-centered, effective, and error-free care.

OVERVIEW OF THE PAPERS IN THIS VOLUME

The following 10 chapters in the volume seek to provide answers to the outstanding questions about health care system finance and consumerism outlined earlier. The chapters are divided into two sections: “Reimbursement, Cost, and Profitability” and “The Move Toward Transparency.” Employing a variety of research methodologies – including advanced quantitative modeling, systematic literature review, narrative review, and expert commentary from Burns and Pauly – in these chapters, authors explore the impact of transformation in payment and debt structures, profitability, and horizontal or vertical integration on outcomes such as price, clinical outcomes, and health plan selection. Additionally, to explore the trend toward transparency between health care stakeholders (patients, hospitals, insurance companies, the government), section two considers how sharing price and outcomes information can enhance patient and payer choice.

SECTION I: REIMBURSEMENT, COST, AND PROFITABILITY

The first four chapters in this volume address the issues of reimbursement, cost, and profitability. These issues are key to understanding how new reimbursement models can serve as a mechanism to achieve the goal of higher performance in health care organizations. The first chapter, by Gascon and Sawchyn, presents a narrative review of the history of bundled payment programs – a mechanism to align payer, provider, and patient incentives. The authors evaluate bundled payment through the lens of agency theory and then postulate the future direction of bundled payments as a key structure in the provision and payment of health services.

The second chapter, by Rosko, uses advanced quantitative modeling to assess the internal and external environmental factors that affect variations in rural hospital profitability. More specifically, the chapter focuses on the impact of the

ACA regulations that resulted in the expansion of Medicaid eligibility, as well as four Medicare programs that target rural hospitals. He found that while the Medicaid expansions provided modest help for rural hospitals' financial condition, the impact of the four targeted Medicare programs for rural hospitals was either small or insignificant. This study speaks to the resources at-risk hospitals need in this era of health care transformation. Rural hospital managers cannot rely on current government programs to remedy their long-standing financial problems, but must consider other mechanisms such as system membership, a factor this study found significantly associated with profitability.

The third chapter, by Ramamonjarivelo, Hearld, Epané, McRoy, and Weech-Maldonado, is a quantitative study of the impact of public hospitals' privatization on community orientation. Their findings suggested that ownership conversion from nonprofit to for-profit increases the likelihood of hospitals engaging in community orientation activities. This surprising finding indicates that conversion to for-profit status indeed has implications for how organizations are serving their local communities. Those proposing new reimbursement models must consider how those models change incentives in the industry to privatize.

The fourth chapter in Section I, by Carroll, Smith, and Wheeler, explores another potential benefit of system membership by addressing the question: "Does system membership help hospitals achieve optimal leverage?" Using propensity score-matched control hospitals, they examined changes in leverage that occurred after independent hospitals joined multihospital systems. This chapter presents the evidence that system membership allows underleveraged hospitals to increase their debt holdings, suggesting that system membership may help not-for-profit hospitals attain an optimal capital structure.

SECTION II: THE MOVE TOWARDS TRANSPARENCY

The chapters in Section II explain how transparency in the health care system can serve as a mechanism to motivate health care organizations to achieve the goal of higher performance. The chapters explore transparency via three broad topics: price transparency, market transparency, and quality metric transparency. The first chapter in this section is an expert commentary written by Burns and Pauly that considers the question: "When is medical care price transparency a good thing, and when isn't it?" They propose that any new policies to promote price transparency must take the specific market setting into account. Therefore, they present an analysis of markets characterized by monopolistic, oligopolistic, and competitive conditions to determine when and under what economic and managerial circumstances price transparency will be useful. This chapter concludes with a nuanced answer to that question, which can be summarized as "not always."

Following this is a chapter by Patel, Rucks, and Ford presenting an analysis of hospital websites to assess compliance with federal regulations requiring hospitals to publish their "standard charges" in a public, machine-readable format. The authors also conducted a sentiment analysis to evaluate the level

of consumer-friendliness of the content in terms of language usage. The authors conclude that most hospitals' websites do not present standard charges data in a way that is readily collectable or comparable to other facilities. In fact, the messaging on webpages routinely suggests that consumers not use the data.

Following the discussions on price transparency, Bauhoff, Carman, and Wuppermann provide a chapter about transparency in insurance markets, particularly exploring the role of consumer financial literacy in health plan choice on the ACA insurance marketplaces. They note that while low-income consumers are eligible for subsidies to purchase insurance, whether these consumers can take advantage of the support and make sound decisions about buying health insurance depend on their knowledge and skills in navigating complex financial products. Their analysis of financial literacy across income groups found that among the low-income population eligible for subsidies, financial literacy was low. This finding is important for ongoing health care transparency efforts and points to a need for targeted support to consumers.

The last three chapters in this volume consider transparency of quality metrics. Aydin, Zengul, Quintana, and Ozaydin present a systematic literature review addressing the question: "Does transparency of quality metrics affect hospital care outcomes?" They identified 39 articles that studied the impact of the public release of quality performance data on hospital care outcomes. They documented a growth in health care transparency efforts between 2010 and 2015, with the increasing number of studies over this time period showing mixed results on outcomes positive, negative, and neutral. Next, McCaughey, McGhan, and Landry explore transparency within a hospital and the links to leadership and safety excellence. Their analysis of employee safety culture surveys found that ratings of safety climate leadership factors by hospital support workers – e.g., food and nutrition, environmental services – were related to perceived safety climate, highlighting the need for transparent leadership across the organizations.

In the final chapter in this volume, Helmchen presents an alternative to current health care transparency efforts that tend to mainly focus on posting provider-specific patient outcomes. Noting the same limitations to this type of transparency as previous chapters, he proposes a system of "outcome warranties" in which providers underwrite insurance policies that promptly pay patients a pre-determined sum after an adverse outcome. Patients could then use these outcome warranties to infer quality differences among providers. He aims to propose a novel, controversial idea to highlight flaws in the current policy and advance the conversation.

The chapters in Section II all support the claim made by Burns and Pauly in this section's first chapter that price transparency is not always a good thing. It depends on a multitude of contextual factors related to consumer's capabilities and the organization of the information. This section supports the complexity of consumer transparency as a mechanism to reach the goal of high-value health care, and makes a case for future research in this rapidly changing field. This is complementary to Section I, which presents a consideration of how new reimbursement models have transformed the finance of health care organizations. As we offer in our Introduction, health care organizations and consumers are the two

key stakeholders simultaneously impacted the most by the goal of high performance and essential for its successful attainment. We hope that health care scholars and practitioners will find this volume of interest.

Jennifer L Hefner
Mona Al-Amin
Editors

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