We’ve heard about rising health care costs for years. Health care experts, researchers, government officials, and clinicians have taken stabs at a variety of methods to cut costs. However, we have no true way of assessing whether those efforts are working because we cannot assess the “true” cost of health care in the United States.

The goal is noble: to benchmark the per capita cost of care in order to control or even reduce it, making health care affordable for all. But the devil is in the details. For example, what should be used for comparison, the list price of a service or procedure, or only the patient’s portion of the cost? And how can we ever determine the true cost to society, which encompasses both direct and indirect aspects of care?

Regardless, our state is ahead of most of the country in developing this benchmark. Already a national leader in health care transparency, researchers in Minnesota have developed the Total Cost Index (TCI), a methodology that is gaining acceptance. TCI is the basis for our efforts to determine the Total Cost of Care, which is making progress toward successful implementation. This endeavor is setting the foundation to truly evaluate the state’s cost of care for the first time.

Challenges
Why has the true cost of care been so elusive? There are many reasons.

- Medical records do not have cost information, so the only central source is insurance claims. This means that a doctor does not know what other doctors get paid for the same service.
- There is no perfect way to attribute one patient’s costs to one health care provider or medical group, because patients often switch providers and groups.
- The actual amount paid for any given service varies by payer (e.g., insurance, Medicare, Medicaid), network, and moment in time.
- Services are reported by medical groups in different ways, including as the unit price of a single procedure; the grouped price for an episode of care; or as the total cost of care for a patient over a set amount of time.
- Finally, since cost is a continuous variable, risk adjustment and outlier rules need to be applied so that a few patients with high-cost medical conditions don’t skew the entire result. Patient costs can vary from $1 to $1,000,000 or more, so the calculation methodology must account for those differences and not be misled by them.

Despite these challenges, Minnesota is getting closer to finding a way to accurately determine the total cost of care.

Standardized measure of cost
The cornerstone to creating a stable, consistent cost-of-care measure is common methodology agreed upon by providers, payers, and health economists.

The TCI was developed in Minnesota and endorsed by the National Quality Forum (NQF)—the gold standard in health care measurement—in January 2012. It is a measure of a primary care doctor’s risk-adjusted cost-effectiveness at managing his or her patients. TCI includes all medical costs involved with treating patients, including provider and facility fees, inpatient and outpatient care, pharmacy, lab, radiology, behavioral health services, and other ancillary costs.

TCI
This measure is preferable to other methods because it is:

- Standardized
- Complete; it measures all costs.
- Repeatable; it can be delivered across payer sources and across time.
- Affordable; most payer databases can calculate it with few additional resources.
- Stable; it reduces the impact of a small number of high-cost patients.

Standardization and stability are particularly crucial in order for
the information to be actionable for medical groups and providers. Historically, providers have been known to get contradictory results due to different methods of measurement that depended on who was doing the measuring, and how. A single, consistent methodology, along with a process to validate the data, means it can be a trusted barometer of cost upon which to base improvements in efficiency.

Putting cost measurement into practice
While arriving at a nationally endorsed, standardized measure of cost and resource use (TCI) was a monumental milestone in 2012, it was still only the first step in the process to determine the true cost of care. The next step occurred when MN Community Measurement (MNCM) began work to develop TCI from a methodology into a publicly reported measure.

Over the course of 18 months beginning while TCI was still under evaluation by NQF, MNCM assembled a multi-stakeholder group charged with finding a way to put TCI methodology into practice. This group included representatives of health plans, provider groups, purchasers, and state officials.

Their collaboration required agreement on how to attribute patient costs to clinics and medical groups, how to risk-adjust the data, and what methods of collection and calculation to use. This work resulted in the specifications for a Total Cost of Care (TCOC) measure.

Data needed to calculate the TCI is gathered from multiple health plans in Minnesota. Unlike many multipayer cost measures, this process does not require an all-payer database. Therefore, administrative costs are lower and there is no risk to protected health information. Additionally, a system for clinics and medical groups to verify the assignment of patients has been built into the process. This verification step is critical to the success of the measure, as is support from the provider community.

Pilot studies
In 2013, MNCM successfully tested the data collection and calculation processes using data from two health plans. The validation process was tested with several volunteer clinics. A full pilot study that involved all major commercial health plans in Minnesota was completed early in 2014. Currently, data collection is underway for a measure that could be publicly reported in the near future, possibly before the end of 2014.

Additionally, total cost information can be bundled with an evaluation of resource use, to provide clinics and medical groups with the most actionable information on cost. A resource-use methodology was also developed in Minnesota and endorsed by NQF at the same time that the same organization endorsed the TCI. To evaluate resource-use methodology, a standardized pricing system is used to measure the utilization variation between providers. MNCM will convene stakeholders to evaluate a resource-use measure after TCOC is available.

Together, the TCOC and resource-use measures would provide targeted information for providers about their costs and how those stack up against their competitors. This complete view of cost and utilization would allow medical groups and clinics to more easily identify areas where they can be more efficient.

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Impacts on other communities
In addition to working toward these goals for Minnesota clinics and medical groups, MNCM has joined forces with the Network for Regional Healthcare Improvement (NRHI) and four other regional health improvement collaboratives in a seminal study on health care cost. The 18-month study will identify the drivers of regional health care costs, and develop strategies to reduce health care spending and improve health care quality at the community level.

The NRHI study, funded by the Robert Wood Johnson Foundation, represents the first time that standardized information will be available across several communities to compare the cost of care across multiple data sources.

“We know the cost of care in Minnesota is lower than in many other states,” says Jim Chase, president of MNCM. “We hope to better understand the differences in these costs, what drives these differences, and how to reduce costs while improving patient care.”

Using the data from the study, the five partnering organizations will create a process for benchmarking health care costs; identify the best ways to share information with the public; and conduct focused efforts with physicians to help them adopt practices that will reduce costs while maintaining the quality of care.

The four other organizations participating in the study are Maine Health Management Coalition Foundation; Center for Improving Value in Health Care in Colorado; Oregon Health Care Quality Corporation; and the Midwest Health Initiative, located in the St. Louis region.

A level playing field
Most providers don’t really know where they stand on cost compared to others, either locally or nationally. In addition, when providers refer their patients to other medical professionals, the cost and utilization of the referral clinics often is not clear.

With Minnesota leading these efforts both locally and nationally, it’s our hope that providers soon will have standardized tools and information to use in comparing their cost and utilization patterns to others. That will enable them to identify opportunities to get better value for their patients.

And that is when controlling or even reducing costs can truly begin to happen.

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