Report on Healthcare Quality and Cost Transparency

from the

Iowa Healthcare Collaborative

Community Advisory Council

to the Iowa General Assembly

January 12, 2009

IHC
Iowa Healthcare Collaborative
A Partnership for Quality, Patient Safety & Value

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To: The Honorable Jack Hatch, Iowa Senate

The Honorable David Johnson, Iowa Senate

The Honorable Lisa Heddens, Iowa House of Representatives

The Honorable David Heaton, Iowa House of Representatives

From: Thomas C. Evans, MD

President

Iowa Healthcare Collaborative

Re: Healthcare Quality and Cost Transparency Report

I am pleased to deliver this final report of the Iowa Healthcare Collaborative's Community Advisory Council on Healthcare Quality and Cost Transparency, as outlined in House File 2539, 2008 Iowa General Assembly. The Collaborative's Board of Directors and Community Advisory Council very much appreciate the opportunity to provide information to the General Assembly on this important topic.

I would be happy to speak with you or members of the legislature as you desire to discuss this report, including its findings and recommendations. Thank you again for the opportunity to provide this information.

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Executive Summary

Section 67 of House File (HF) 2539 directed the creation of a "health care quality and cost transparency work group" to develop, within prescribed parameters, legislative and policy recommendations regarding health care quality, cost and transparency. The recommendations were to be submitted in a report to the General Assembly on or before December 15, 2008. As a result of the summer flooding and related events in the state, the legislature determined not to convene the workgroup

Instead, in response to legislative request, the Iowa Healthcare Collaborative (IHC) Community Advisory Council (CAC) agreed to conduct the following review of the tasks set forth under section 67 of HF 2539 for the purpose of offering recommendations to the Iowa General Assembly early in the 2009 legislative session.

In the report that follows, the CAC outlines its research, findings, and recommendations in response to the charge in HF 2539. This report includes sections describing approaches in other states to the questions of healthcare data and transparency, practices for collection and reporting in Iowa, and recommendations for next steps on these questions for state policymakers.

The Community Advisory Council provides the following recommendations to the legislature:

1. Reporting of healthcare quality and cost measures

    a. More should be done within the state to continue to responsibly focus the measure set collected and reported in Iowa. Efforts like those led by the Iowa Healthcare Collaborative, Iowa Health Buyers Alliance, AARP, Health Policy Corporation of Iowa, health plans and others should continue as a way to investigate new reporting opportunities and to build consensus among stakeholders on measures to be included in these efforts. Data reporting should be focused on “highly-leveraged” metrics, as discussed in the National Priorities Partnership report, recently released by the National Quality Forum.

    b. A focus on alignment with national efforts with regard to public reporting should continue. Any additional measures collected and reported in Iowa should agree with nationally recognized standards, ensuring comparisons with healthcare providers in other states.

    c. To minimize reporting burden, care should be taken to choose metrics and reporting schemes that balance the needs of the public for information with the burden that might be created for the reporting entities.

2. Strategies to lower healthcare costs and health coverage costs for consumers and businesses

a. Healthcare providers offer the greatest opportunity to improve quality and reduce cost through changed processes. IHC should be tasked with a directive to promote greater distribution and usability of its annual Iowa Report so that healthcare providers are able to use this tool effectively in their cost and quality improvement efforts.

b. For healthcare consumers, similar to healthcare providers, the CAC should make substantial efforts to promote the availability of useful cost and quality information to consumers. This consumer-oriented information should empower more active consumer decision-making in their personal care and more active purchasing decisions in their utilization of healthcare. Recommendations here include:

    i. Development and use of indices to more clearly communicate complex healthcare performance.

    ii. The CAC should be directed to make this information available in many formats (paper, web-based, and other electronic formats) for ready accessibility to the general public.

    iii. Identify partner organizations with existing communication vehicles to better promote distribution and effective use of this information

    iv. Explore new types of distribution channels utilizing employers, insurers, points of care, public agencies, etc.

c. Iowa healthcare providers must continue using data to benchmark improvements in the process of care which use Lean or other effective process improvement practices.

d. Efforts should be made to analyze and include emerging measures of efficiency to inform and support the development of a sustainable healthcare system. The CAC can provide important input into this work for Iowans.

3. IHC should be encouraged to evaluate collection of additional healthcare provider specific data.

    a. IHC should explore the feasibility of developing a physician all-payer database.

    b. IHC reporting should take a specific focus on variations in the delivery of care to enable hospitals and physicians to benchmark their performance against other providers of care and understand where improvements can be made in order to improve quality overall.

4. Promote the Patient-Centered Medical Home (PCMH) model of care in Iowa. As efforts are made toward implementing this new model of care for the state, IHC should provide support to physicians in developing their understanding of the requirements and enabling their effective execution of the PCMH model.

5. Health information technology is a fundamental building block of the national strategy to promote healthcare transparency.

    a. Iowa leaders should interact with federal officials to promote national solutions, such as the promotion of technology interoperability standards and a national standard patient identifier to assist in tracking episodes of care for patients. This will also enable more effective implementation of the PCMH model.

    b. State government, working with the federal government, should support development of information technology to automate collection and analysis of cost and quality data to reduce the burden of collection on reporting entities.

    c. State government should also strongly consider tax incentives for physicians who invest in health information technology.

Introduction

National organizations evaluate the quality of Iowa's healthcare system as high. Within the past several years, high marks have come from the federal Agency for Healthcare Research and Quality, and The Commonwealth Fund, among others. And while our quality is high, healthcare stakeholders - ranging from employers, union representatives, government officials, insurers, and healthcare providers - know that more improvements are possible with coordinated, collaborative efforts. The question for these collaborative discussions often is where the emphasis should be placed as improvement efforts are undertaken.

Through its recent report "National Priorities and Goals"[1] , a broad-based group of national stakeholders convened by the National Quality Forum has emphasized that our comparisons must be made not only within our own country, but within the world stage. As we look to achieve world-class healthcare, we should also be open to looking for both national and international ideas on approaches to improvement.

Today, as never before, there is a growing recognition regarding the intrinsic interplay among affordability, access and quality. Virtually every access proposal introduced and/or passed by a state legislature contains a provision to convene a group to study and make recommendations concerning cost and quality. Many states have mandated the collection of inpatient and ambulatory surgery data, financial data, healthcare-associated infection typology data and more recently, data regarding "never" events. In the past ten years, numerous expert panels and a growing body of evidence have documented serious gaps in safety and quality which has led to many promising, evidence-based improvements that have begun to take hold, representing progress that is saving not only money, but lives. Across the country, new models of care are emerging, built on expanding knowledge about how to deliver effective and efficient care.

Yet, with this growing evidence base, more demand is being placed on healthcare facilities and providers to adopt new methods of care while continuing to provide critical access to services within our communities. The Institute of Medicine, in its 2006 report[2] on performance measurement, expressed a particular concern over the healthcare workforce, noting that it is showing signs of stress and fatigue resulting from too many quality and performance improvement initiatives and too few resources to address them. Even the national organizations engaged with the National Quality Forum's "National Priorities and Goals" report have focused on the identification of "high-leverage areas" – those with substantial opportunities for improvement – as a way of encouraging rapid deployment of highly targeted change, and thus, improvements in the healthcare delivery system.[3]

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1 National Priorities Partnership. *National Priorities and Goals: Aligning Our Efforts to Transform America's Healthcare.* Washington, D.C.: National Quality Forum; 2008. http://nationalprioritiespartnership.org/uploadedFiles/NPP/08-253-NQF%20ReportLo%5b6%5d.pdf

2 Institute of Medicine, *Performance Measurement: Accelerating Improvement*, Washington, DC: The National Academies Press; 2006: pp.76-77.

3 National Priorities Partnership, p. 7

To improve our results, we must fundamentally improve the ways in which we deliver care. That requires joint efforts by patients, healthcare organizations, health care professionals, community members, payers, suppliers, government organizations and all other stakeholders in healthcare.

In Iowa, the Iowa Healthcare Collaborative is an initiative that brings together such key stakeholders for the specific purpose of promoting the development, deployment, and execution of an effective, quality-driven, value-based healthcare system in Iowa. In this report, the Community Advisory Council delivers information and recommendations regarding next steps in Iowa for highly targeted data and reporting initiatives which will support Iowa healthcare providers and consumers.

I. Background on the Healthcare Reform Act-HF 2539- and Data Transparency Workgroup

Section 67 of HF 2539 directed the creation of a "health care quality and cost transparency work group" to develop, within prescribed parameters, legislative and policy recommendations regarding health care quality, cost and transparency. The recommendations were to be submitted in a report to the General Assembly on or before December 15, 2008.

HF 2539 provided that the members of the work group, which was to include representatives of the Iowa Healthcare Collaborative, be appointed by (and funded through) the Legislative Council in consultation with the chairpersons and ranking members of the Joint Appropriations Subcommittee on Health and Human Services and the chairpersons and ranking members of the Committee on Human Resources of the Senate and House of Representatives. However, due to unexpected budgetary restrictions in the aftermath of the summer flooding in Iowa, the Council declined to convene or fund the work group.

The IHC was subsequently approached on September 4, 2008, by Senator Jack Hatch, as Co-Chair of the Health and Human Services Appropriations Subcommittee. Senator Hatch requested that, in lieu of the work group, the IHC undertake the work set forth under the bill. He also stated his expectation that the IHC work with what would have otherwise been the intended membership of the workgroup, had it been convened: “the Department of Public Health, the Department of Human Services, the Division of Insurance, the Iowa Hospital Association, the Iowa Medical Society, the Iowa Health Buyers Alliance, the AARP (Iowa Chapter), the University of Iowa Public Policy Center and other interested consumers, advocates, purchasers, providers and legislators.”

The Community Advisory Council substantially mirrors the membership of the legislatively authorized workgroup. The Charter of the CAC includes, in part:

The purpose of the Community Advisory Council (CAC) is to engage all four stakeholder groups in healthcare delivery in a respectful, positive, and fruitful interchange to promote the development, deployment, and execution of a quality-driven, value-based healthcare system in Iowa. The CAC promotes the four cornerstones of value-driven healthcare (interoperable health information technology, measure and publish quality information, measure and publish price information, incentives to promote quality and efficiency of care), and provides advice and input to other IHC activities.”

Members of the Community Advisory Council include the following:

John Aschenbrenner
President, Insurance & Financial Services
Principal Financial Group
Des Moines

Garth Bowen
Labor Chairman
Iowa Health Buyers Alliance
Des Moines

Angela Burke Boston*
Iowa Insurance Division
State of Iowa
Des Moines

Anthony Carroll
Associate State Director for Advocacy
AARP
Des Moines

Nicky Cooney
Medical Center Senior Sales Professional
Sanofi-aventis
Iowa Falls

Jim Crotty
Director, South Central Unit 8
Iowa State Education Association
Des Moines

Peter Damiano, PhD*
Director, Public Policy Center
University of Iowa
Iowa City

Denise Essman
President and CEO
Essman and Associates
Des Moines

Tom Evans, MD
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Charles Helms, MD, PhD
Medical Director, Ofc of Clinical Quality, Safety & Performance Improvement
University of Iowa Hospitals and Clinics
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Ed Holland, CEBS
Risk and Benefits Manager
Iowa Department of Administrative Services
Des Moines

Bruce Koeppl
State Director, Iowa State Office
AARP
Des Moines

Eric Kohlsdorf
President and Chief Strategist
Prisma, Inc.
Des Moines

Don Lovasz
CEO
Iowa Foundation for Medical Care
West Des Moines

Val Newhouse, MA
Executive Vice President
Iowa Lakes Community College
Estherville

Tom Newton, MPP, REHS
Director
Iowa Department of Public Health
Des Moines

Paul Pietzsch, MPH
President
Health Policy Corporation of Iowa
Johnston

Mark Purtle, MD
Vice President, Medical Affairs
Iowa Health-Des Moines
Des Moines

Mike Ralston
President
Iowa Association of Business and Industry
Des Moines

Ronald R. Reed, MPH
President and CEO
Mercy Hospital - Iowa City
Iowa City

Peter Roberts
Group Vice President
Wellmark
Des Moines

Elliott Smith
Executive Director
Iowa Business Council
Des Moines

Mark Valliere, MD
Senior Vice President of Medical Affairs
Mercy - Cedar Rapids
Cedar Rapids

Jennifer Vermeer
Director, Iowa Medicaid
Iowa Department of Human Services
Des Moines

James Wells, SPHR
Employee Services Manager
City of Des Moines
Des Moines

* Member added to CAC for purposes of the work under HF 2539

The IHC agreed to facilitate the following review of the tasks set forth under section 67 of HF 2539 for the purpose of offering recommendations within the legislation's defined parameters to the Health and Human Services Appropriations Subcommittee and House and Senate Human Resources Committees early in the 2009 legislative session.

While the recommendations communicated in this report can be effectively executed in state policy, efforts should be made by state policymakers and other healthcare stakeholders to continually reassess health data collection and reporting needs. National organizations are continually developing new strategies to address information needs. Healthcare research continues to develop new methods of measuring performance. And practical experience over time tells us that data collection, reporting, as well as provider and consumer information needs change over time. This report should be seen as the beginning of a longer term statewide dialogue to promoting transparency and quality improvement in Iowa's healthcare delivery system.

In the report that follows, the CAC outlines its research, findings, and recommendations in response to the charge in HF 2539. This report includes sections describing approaches in other states to the questions of healthcare data and transparency, practices for collection and reporting in Iowa, and recommendations for next steps on these questions for state policymakers.

II. Other State and National Approaches to Transparency in Cost and Quality

Variable Approaches and Availability

The difficulty in our current system of healthcare measurement and reporting is that there is no national system, or structure, for performing this work. Instead, we have a patchwork of approaches that have been piecemealed together over time, by various stakeholders and for different purposes. Thus, it becomes confusing for professionals in the industry, and even more so the public, to make sense of all the information that is available. Historically, states have collected data from hospitals and other providers for a variety of reasons: to facilitate planning of their health care delivery systems; to aid in improving their citizens' health; and to study the outcome and effectiveness of health services, utilization of services, and payment methods. More recently, states have begun mandating the collection of additional data focused on measuring performance on indicators like infection rates, "never events", patient safety and other quality indicators as a way of better understanding how the healthcare system is performing.

Barriers Created by Inconsistency

The variability in states' quality and safety reporting efforts results in some unintended consequences. Primarily, without a holistic national approach to healthcare measurement and reporting, it becomes difficult to compare performance between providers, localities, regions, and the nation, within particular settings across time – spurring additional attempts to measure performance with disparate data and metrics which increases variability. More recently, there's been a renewed focus at the national level to "harmonize" measures and on increasing the transparency of health care information to improve quality, increase competition, and ultimately curb the growth in health care spending – primarily due to state's varying levels of familiarity and use of these measures, and in the way federal laws for certain reporting mechanisms were written.

Case for National Standardization and Common Measures

President Clinton's 1996 Advisory Commission on Consumer Protection and Quality in the Health Care Industry envisioned a U.S. entity that would be responsible for: (1) implementing a comprehensive plan for measurement and reporting; (2) identifying core metrics for measurement and reporting; and (3) promoting the development of the core measures. The National Quality Forum (NQF) represents the culmination of this vision and was established in May 1999, by a White House-convened planning committee. [4] The Iowa Healthcare Collaborative and other organizations represented on the Community Advisory Council recognize the current and potential value of NQF's role as a national consensus body in endorsing evidence-based practices and measures. In general, the National Quality Forum's efforts are noteworthy as they are working toward the harmonization of healthcare practices and measures, as well as focusing national efforts on health issues that have high potential return on investment.

The proliferation of metrics and reporting requirements is becoming burdensome to providers. For example, an Iowa hospital recently reported that they now track 450 performance measures originating from a plethora of various organizations – National Quality Forum, Joint Commission, Centers for Medicare and Medicaid Services (CMS), American College of Cardiology National Data Registry, Society of Thoracic Surgery National Database, and others.[5] Also, an estimate based on a sample of CareScience customers shows that it takes between 50 and 90 hours to collect data for the Joint Commission's (JCAHO) Core measures for AMI, heart failure, and pneumonia. It takes approximately 23 hours per month to analyze the data. The cost associated with extracting, entering, submitting, and analyzing this data – which represented about 16% of a hospital's inpatient data for these measures - was approximately $77,000 to $100,000 annually. [6]

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4 McGlynn EA. Introduction and Overview of the Conceptual Framework for a National Quality Measurement and Reporting System. *Medical Care.* 2003;41(1)(Supplement):I1 - I7

5 Clancy TR, Clancy G. External Quality Reporting Requirements: Their Impact and How to Respond at the Management and Board Level. Paper presented at: Iowa Hospital Association Annual Meeting; October 9, 2008; Des Moines, Iowa.

6 Anderson KM, Sinclair S. Easing the Burden of Quality Measures Reports. *Hospitals & Health Networks* [http://www.hhnmag.com/hhnmag_app/jsp/articledisplay.jsp?dcrpath=HHNMAG/PubsNewsArticle/data/2006August/060815HHN_Online_Anderson&domain=HHNMAG. Accessed October 7, 2008.

An examination of the more nationally-recognized healthcare toolsets and measures indicates that there is some evidence of national "harmonization" of measures and reporting vehicles. For example, over the past several years, NQF has endorsed patient safety/quality/utilization outcome and process measures, infection measures, safe healthcare practices, and survey items that assess patients' actual experiences with the health system. But there still exists considerable variability.

The following sections outline this variability in measuring healthcare performance.

Agency for Healthcare Research and Quality (AHRQ) Quality Indicators (QIs)

The AHRQ QIs are a set of quality indicators used to measure healthcare quality, safety, utilization, prevention, and patient safety outcomes, and rely on hospital discharge data for their calculation. Thus, they are relatively easy and inexpensive to use. AHRQ QIs are currently being reported publicly by 14 states including Iowa, however many other states are inquiring about how to use AHRQ's QI tools or have plans to implement these soon (Appendix, Table 2). [7] These indicators span many types of measures – patient safety, "never events" (discussed below), inpatient quality, pediatrics, volume, nursing sensitive, infection prevention, chronic and acute conditions, community-centered prevention, and over/under-utilization of services.

The data to drive the AHRQ QI analysis comes from hospital discharge data. While this data is common hospital data, a July 2008 summary provided by the National Association of Health Data Organizations (NAHDO) found that just 40 states (AZ, AR, CA, DE, FL, GA, IL, IN, IA, KS, KY, LA, ME, MD, MA, MN, MS, MO, NV, NH, NJ, NM, NY, NC, ND, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VT, VA, WA, WV, and WI) and the District of Columbia mandate the collection of some type of all-encompassing healthcare data. The data collected are primarily inpatient, outpatient, and emergency department (ED) data and reported to hospital associations and/or a public agency. Within these 40 states; 36 collect inpatient data, 21 collect outpatient data, and 18 collect ED data (Appendix, Table 1). [8]

Centers for Medicare & Medicaid Services (CMS)

Based on a 2003 federal law, only those U.S. hospitals that are paid for their Medicare patient services using the inpatient prospective payment system (IPPS) must self-collect and report data on a set of process measures targeting common and costly U.S. conditions - heart attack, heart failure, pneumonia, and surgical infection (Appendix, Table 2). These IPPS hospitals must report all measures in order to receive annual payment updates and have their measures publicly posted on CMS' Hospital Compare website quarterly. In essence, this is a "pay-for-public reporting" program. However, it is notable that this law exempts a good portion of U.S. hospitals – mainly small, rural hospitals that, via a 1997 law, are paid for their Medicare services in a different way.

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7 Agency for Healthcare Research and Quality. *Key Choices in Analyzing Data*; Quality Indicator Learning Institute (QILI), Presented at QILI webinar December 15, 2008.

8 NAHDO. Summary of Healthcare Reporting for Members of the National Association of Health Data Organizations. http://nahdo.org/cs/media/p/458.aspx. Accessed October 6, 2008.

CMS continues to add new measures to this "pay-for-reporting" program over time – most recently adding mortality outcome measures and patients' hospital experience survey measures. Thirteen additional measures are due to be added to this program in federal fiscal year 2010 including heart failure readmission, failure to rescue Medicare patients, participation in a cardiac surgery registry, and additional infection prevention process measures. Additionally, as evidence of national standardization efforts, CMS will be adding 9 AHRQ QIs as required "pay-for-reporting" measures.

However, CMS is beginning to shift to a "pay-for-performance" scheme. For example, starting October 1, 2008, CMS began to withhold payment to IPPS hospitals for 10 categories of hospital-acquired conditions (HACs). Following CMS' lead, approximately 20 to 25 states already have or are considering methods to eliminate payment for similar events that should not occur (Appendix, Table 3). [9] [10] In total, this will bring the total number of measures that must be reported to CMS to 42 in federal fiscal year 2010; and 10 categories of HACs will not be paid for by CMS and perhaps by other payers depending upon other state's efforts to stop payments for HACs.

Finally, other healthcare settings will likely be impacted by additional regulatory requirements. For example, CMS' regulatory "final rules" for 7 proposed outpatient process measures were released in November 2007. These rules initiated the measurement of outpatient services spanning emergency department heart attack/chest pain patients and outpatient surgical infection prevention. However, CMS has not determined when the measurement data will be released publicly.

Healthcare-associated Infection (HAI) Data

Twenty five states currently have some sort of mandated approach to HAI measurement and/or reporting.[11] Although there is considerable variability in the types and scope of infection measures, most states have chosen to focus on outcomes measures: 20 states mandate and 3 states are proposing mandates to use the CDC's National Healthcare Safety Network (NHSN) system to define and collect HAI outcomes data. For process measures, 10 of 13 states utilizing HAI process measures mandate the use of CMS' Surgical Care Improvement Project (SCIP) measures. However, these 10 states' efforts are somewhat duplicative as federal law already mandates IPPS hospitals to report these measures for public reporting and pay-for-reporting purposes. In terms of typology, most current state mandates focus on central-line bloodstream, surgical and ventilator-associated pneumonia-related infections. However, many states currently have, or are considering, legislative mandates focusing on the surveillance and/or

9 National Academy for State Health Policy. 2005. Retrieved 10/9/2008 at http://www.nashp.org/_docdisp_page.cfm?LID=2A789909-5310-11D6-BCF000A0CC558925.

10 Centers for Medicare & Medicaid Services. July 31, 2008 Press Release: Medicare and Medicaid Move Aggressively to Encourage Greater Patient Safety in Hospitals and Reduce Never Events. Retrieved 10/27/2008 at http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=3219&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=1%2C+2%2C+3%2C+4%2C+5&intPage=&showAll=&pYear=&year=&desc=false&cboOrder=date

11 Consumers-Union. StopHospitalInfections.org. http://www.stophospitalinfections.org/learn.html. Accessed October 2, 2008

prevention of a particularly costly and life-threatening form of infection - methicillin-resistant staphylococcus aureus (MRSA). (Appendix, Table 4).[9] [12]

Serious Reportable Events / "Never Events"

In 2002, the National Quality Forum (NQF) released an initial list of 27 "serious reportable events" – also known as "never events" - in healthcare that should be preventable. For example - a foreign object (instrument, tool, or substance) should not be left in a patient during surgery; a patient should not die due to a medication error; or a patient should not receive the wrong type of blood. One event has been added to the list to bring the current total to 28 "never events". As mentioned before, since 2002, CMS and several states have moved to legislate the reporting of many or all "never events" (Appendix, Table 3), and many payers – CMS, states, private insurers - are limiting or denying payments to providers in instances when the patient was subjected to a "never event".

Health Provider Pricing Information and Cost Comparison: Episodes of Care

The U.S. Department of Health and Human Services (HHS), as well as organizations in the private sector, is encouraging strategies to measure the overall cost of services for common episodes of care and treatment of common chronic diseases.

Public and private employers, government entities, consumer groups, health plans and providers signing on in support of Value-Driven Health Care, sponsored by the U.S. Department of Health and Human Services, pledged to support provider pricing information comparison. They agreed to request that those with whom contracts are established participate in broad-based national public-private collaborative efforts to develop appropriate strategies to measure the overall cost of services for common episodes of care and the treatment of common chronic diseases, while avoiding undue administrative burden on healthcare providers.

In this regard, HHS recently reported that the Robert Wood Johnson Foundation is providing funding to create episodes-based-cost-of-care measures for 20 common conditions. The Brookings Institution is working with the American Board of Medical Specialties and others on this project. They are developing cost of care measures which are intended to become nationally endorsed. They plan to have 20 conditions completed for consideration by the NQF by early to mid-year 2010.

Other State Efforts in Reporting Quality and Costs

Among other states publicly sponsoring efforts to collect and report data on quality and cost are two states of particular note: Florida and Pennsylvania.

Florida: The state of Florida leads the nation in public reporting of health care information to residents. Their website, www.FloridaHealthFinder.gov, provides information on costs, quality and errors in hospitals. Florida adopted mandatory hospital

12 General Accountability Office. Healthcare-associated Infections in Hospitals: An Overview of State Reporting Programs and Individual Hospital Initiatives to Reduce Certain Infections. September, 2008; GAO-08-808.

infection reporting in 2004. In November 2005, Florida became the first state to publicly report infection and mortality rates in each hospital.

Pennsylvania: The Pennsylvania Health Care Cost Containment Council has existed for many years, actively publishing information on quality and cost of care for healthcare providers in the state. Recently, the agency reported on the high costs of infections in both dollars and lives and on cardiac surgical performance in Pennsylvania.

Collecting and Reporting Financial Information –State Approaches

States take a variety of approaches in their provider reporting laws in both the scope of provider entities required to report information, as well as the actual financial information that must be disclosed. For example, some state laws apply only to hospitals; others apply to hospitals and ambulatory surgical centers; and some apply to all health care providers in the state, including nursing homes and home health agencies.
In addition, the actual financial data that must be reported varies from state to state. For example, some states require that hospitals disclose all rates or charges and some require the disclosure of average charge per inpatient day, per confinement, or for common inpatient or outpatient procedures. A few states require providers to disclose reimbursement information and others require reporting of financial information, but not charges.

A few states use the information reported to address the issue of "cost-shifting." Cost-shifting occurs when one payer group is systematically charged a higher price for the same services to offset a lower price paid by another payer. Data from the American Hospital Association suggests that the gap between payment levels for public programs and private insurance is higher than at any time in the last 15 years.[13] A recently released study by Milliman, Inc., states that: 1) cost shifting adds an estimated $1,512 or 10.6 percent to the average premium for a family of four; 2) of this amount, employers pay approximately $1,115 with the employee share $397; 3) families pay an additional $276 more in coinsurance and deductibles due to cost-shift; and 4) in 2006, the hospital cost shift from Medicare was $34.8 billion and $16.2 billion for Medicaid while in 2007, the physician cost shift was $14.1 billion for Medicare and $23.7 billion for Medicaid for a combined total of $88.8 billion.[14] Overall, the cost shift represents 15 percent of the current amount spent by commercial payers on hospitals and physicians. Stated differently, if there were no cost-shift, hospital and physician costs for privately insured patients would be 15 percent lower. Although a number of states currently collect the information necessary to quantify and analyze the cost-shifting occurring in their state, only Mississippi and Vermont specifically address cost-shifting in their respective laws. Vermont is the only state that produces a report on the issue.

While most states require the information collected to be made public, some do so only in connection with other activity: e.g., information is disclosed in conjunction with a health care facility certificate of need program. Some states' laws are specifically geared toward providing information to consumers to allow them to compare charges or prices for specific hospital services.

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13 2007 Chartbook, Trends Affecting Hospitals and Health Systems, April 2007. American Hospital Association. http://www.aha.org/aha/trendwatch/chartbook/07chart4-6ppt.

14 Milliman, Inc. *Hospital and Physician Cost Shift, Payment Level Comparison of Medicare, Medicaid and Commercial Payers.* December 2008

Specific examples of state approaches for reporting and publishing health care provider financial information are as follows (Appendix, Table 5):

- Ten states (FL, KS, ME, MA, MS, MO, OK, UT, VA, and WI) and DC require all health care providers in the state to report data.

- Some states (AR, CA, GA, IL, KY, LA, NY, NC, NV, OR, PA, and TN) require both hospitals and ambulatory surgical centers to report financial data.

- Seven states (AZ, DE, NV, NH, NM, ND, and RI) require hospitals and residential care facilities, including nursing homes or long-term care facilities, to report information.

- Some states (IN, MN, NJ, OH, VT, and SD) require only hospitals to disclose information.

Scope of financial information reported:

- Seven states (AR, ME, MD, NV, OK, PA, and TN) require disclosure by certain providers of reimbursement information.

- Twenty-three states (AZ, CA, FL, GA, IL, IN, MD, MN, MO, NY, NV, NH, NM, NC, ND, OH, OK, PA, SD, TN, UT, VA, and WI) require reporting of the charges (or average charge) for specific procedures, per discharge, or for diagnostic groups.

- Seventeen states (CA, FL, GA, IN, IA, KS, MA, NV, NH, NJ, OK, RI, SC, UT, VT, WA, and WV) require providers to report financial information about their own business operations.

Financial information made public:

- Twenty-six states (AZ, AR, CA, FL, IL, IN, ME, MD, MA, MN, NV, NH, NY, OK, OR, PA, RI, SC, TN, TX, UT, VT, VA, WA, WV, and WI) make at least some financial information publicly available through a website.

- Ten states (AR, FL, MA, MN, NV, NH, OR, TX, UT, and WI) maintain websites that allow consumers to compare charge or price information for various hospital procedures, although some states only make general price information available.

In addition, a common mechanism used by states to report average and median charge information for common reasons of hospitalization is through the use of a commercial software product developed in the state of Wisconsin called Pricepoint. The Iowa Hospital Association recently noted that 14 states (AZ, GA, IA, NE, NV, NH, NM, OK, OR, RI, TX, UT, VA, WA) currently use the Pricepoint software to drive their public websites – they also note that 6 additional states are in the development stages for using this software (Appendix, Table 5).

Finally, there are also national sources of cost/charge/expenditure information. For example, CMS' Hospital Compare website now publicly posts the median and range of payments paid by Medicare to hospitals for select patient diagnoses.

III. Iowa Reporting of Healthcare Quality and Cost Measures

Like most of the states in the U.S., Iowa has a state mandate to collect healthcare data. Iowa collects all of the three types of data summarized by the NAHDO report – inpatient, outpatient, and emergency department (ED) data. As required by Iowa Administrative Code, all Iowa hospitals submit 100% of their inpatient, outpatient, and emergency room administrative data to the Iowa Hospital Association (IHA). IHA submits this data to the Department of Public Health and then makes it publicly available.

Agency for Healthcare Research and Quality (AHRQ) Quality Indicators (QIs)

The Iowa Healthcare Collaborative utilizes this Iowa inpatient data, along with AHRQ's standardized QI toolsets, to measure and report statewide and hospital-level AHRQ QI performance. In the latest 2008 Iowa Report, IHC reported Iowa performance on 35 AHRQ quality indicators; 17 of these report performance information at the hospital level. In addition, the IHC provided all Iowa hospitals a detailed copy of their AHRQ QI hospital performance – for the past 5 years and 5 years combined - for the 17 AHRQ QIs included in the 2008 Iowa Report, designed to be supportive of hospital quality improvement efforts.

Centers for Medicare and Medicaid Services (CMS)

Many of Iowa's hospitals also report CMS measures to the federal government and their performance is published on CMS' Hospital Compare website. IHC "repackages" this performance information and adds value by enabling providers and consumers to view all Iowa hospitals' performance on one report for multiple years, along with state, national, and national top 10 percent comparisons. The 2008 Iowa Report contains 37 CMS measures, including 4 composite measures of patients' experiences with hospital care.

Healthcare-associated Infection (HAI) Data

Over the past 2 years, the Iowa Healthcare Collaborative and the Iowa Hospital Association have focused on establishing and assisting Iowa hospitals with healthcare-associated infection measurement and reporting using the CDC's National Healthcare Safety Network metric definitions as a nationally-recognized and evidence-based guide for this endeavor. The 2008 Iowa Report contains eight aggregate measures of healthcare-associated infections.

Serious Recordable Events / "Never Events" and NQF Safe Practices

The Iowa Healthcare Collaborative utilizes 2 AHRQ Patient Safety Indicators – Foreign Body Left in During Procedure and Transfusion Reaction (Wrong Blood Type) – to provide an aggregate count of the number of times these events happen in Iowa. These AHRQ measures are included in the 2008 Iowa Report. In addition, the Iowa Hospital Association has instituted a policy that urges hospitals to refrain from billing payers for 8

NQF “Never Events”. Finally, under the new CMS rule, no Iowa hospital is paid by Medicare for the 10 hospital-acquired conditions (HACs) effective October 1, 2008.

National Quality Forum 30 Safe Practices

Since 2004, the Iowa Healthcare Collaborative has fielded two National Quality Forum 30 Safe Practice surveys. These surveys were designed to assess Iowa hospital leaderships’ perceptions of 30 NQF-endorsed “safe practices” in their hospital. The results of these surveys are presented in the 2008 Iowa Report. In addition, all 104 hospitals responding to the latest NQF Safe Practice survey were given a private report of their responses along with comparative statewide averages.

Health Provider Pricing Information and Cost Comparison

Iowans have access to “charge” information for inpatient and outpatient services through the Iowa Hospital PricePoint tool made available by the Iowa Hospital Association. This allows health care consumers to access basic information about services and charges at Iowa hospitals. A hospital "charge" is not the same as "expected payment." "Charge" is the amount billed for a service. In the vast majority of cases, hospitals are paid considerably less than the billed amount. Because each person's case is different based on that patient's medical condition, a given patient's charge will not necessarily be the same as the average or median charge. Furthermore, the actual amount paid by a patient will depend on that patient's insurance coverage. Iowa Hospital PricePoint should be considered a starting point for comparing costs of care between Iowa hospitals.

Iowa Health Buyers Alliance and Health Policy Corporation of Iowa Public Reporting

The Iowa Health Buyers Alliance (IHBA) and Health Policy Corporation (HPCI) use data from various public sources to produce Iowa reports of health care provider quality, patient safety and efficiency. Data sources include Centers for Medicare and Medicaid Services, The Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), The Leapfrog Group, and the Dartmouth Atlas of Health Care. Specific measures reported by IHBA and HPCI include Iowa hospital performance relating to heart attack and heart failure, results from surveys of patient experiences with Iowa hospitals, and ranking of Iowa hospitals’ performance in treating chronic illness. The primary audience for these reports is consumers, patients and their families as well as public and private employers. Of special note is the Iowa Consumers’ Health Guide Series. Four Guides have been published to date: Guide #1: Consumers’ Health Reference Guide, Guide #2: Heart Health Guide with Scorecard – Heart Centers In Greater Iowa, Guide #3: Iowa Report Card, What Patients Say About Their Experiences with Hospital Care in the Greater Iowa Area, and Guide #4: Iowa Report Card, Ranking of Hospitals for Chronic Care, Greater Iowa Area, with What You Can Do to Get Health Care Right? The Guides are made available to employers, unions and others for use on their intranet sites, lunch and learn sessions and in other ways. Communication channels are being established with the Iowa consumer and purchaser community.

Wellmark Blue Cross and Blue Shield Information for Consumers

As a part of its effort to communicate with its insureds, Wellmark Blue Cross and Blue Shield provides information on both physicians and hospitals. Physician information available includes location, medical specialties, credentials and related descriptive information. For hospitals, information available includes such measurements as the number of patients treated, complication and mortality rates for a variety of hospital treatments. Data sources include Medicare, The Leapfrog Group, and other publicly available data. Wellmark also uses data in working collaboratively with healthcare stakeholders through its patient registry database, the introduction of incentives for changing processes and improving quality, and studies on the variability of healthcare.

IV. Recommendations Regarding the Collection and Reporting of Healthcare Quality and Cost Information in Iowa

Based on the work of the Community Advisory Council, five recommendations are made to the Iowa General Assembly regarding the charge put forward in HF 2539. These recommendations are as follows:

1. **Reporting of healthcare quality and cost measures.** This report has outlined that Iowa is very much in the mainstream of collecting and reporting healthcare cost and quality measures. In many cases, even without mandates, Iowa reports more information to the public on healthcare performance than many other states. Additional specific action steps should include:

    a. More should be done within the state to continue to responsibly focus the measure set collected and reported in Iowa. Efforts like those led by the IHC, IHBA, AARP, HPCI, health plans and others should continue as a way to investigate new reporting opportunities and to build consensus among stakeholders on measures to be included in these efforts. Data reporting must be flexible in adjusting metrics collected and reported based on changing needs and research. Data reporting should also be focused on “highly-leveraged” metrics, as discussed in the recent National Priorities Partnership report, issued by the National Quality Forum.

    b. In addition, a focus on alignment with national efforts with regard to public reporting should continue. Any additional measures collected and reported in Iowa should agree with nationally recognized standards, ensuring comparisons with healthcare providers in other states.

    c. Iowa’s healthcare delivery system is predominantly comprised of smaller, rural organizations with constrained resources. All providers currently deal with a vast array of regulatory and voluntary reporting requirements. To minimize reporting burden, care should be taken to choose metrics and reporting schemes that balance the needs of the public for information with the burden that might be created for the reporting entities.

2. **Strategies to lower healthcare costs and health coverage costs for consumers and businesses.** State government should promote healthcare information distribution strategies which promote its effective use by healthcare providers and consumers. Healthcare providers can use the data to direct their efforts at making clinical improvements. Consumers can use the information to make better personal healthcare decisions and better decisions in purchasing healthcare. Specific action steps could include the following:

    a. Healthcare providers offer the greatest opportunity to improve quality and reduce cost through changed processes. Access to and use of data-based information sources is critical to the cost-effective improvement of healthcare delivery. IHC should be tasked with a directive to promote greater distribution and usability of its annual Iowa Report so that healthcare providers are able to use this tool effectively in their cost and quality improvement efforts. This might mean delivery of additional specific data and information to physicians and hospitals and providing assistance to providers as they work to interpret and make adjustments in their delivery of care. IHC is also uniquely positioned to promote learning communities of providers aimed at efforts to drive healthcare improvement throughout the state, putting the findings of evidence-based medicine to practical application.

    b. For healthcare consumers, similar to healthcare providers, the CAC should make substantial efforts to promote the availability of useful cost and quality information to consumers, whether they are the recipients of care, purchasers, payers or policymakers. This consumer-oriented information should empower more active consumer decision-making in their personal care and more active purchasing decisions in their utilization of healthcare. To achieve this, information must be relevant to the needs of consumers as they access care, and must be understandable so as to be actionable.

        i. The development and use of indices can be useful in order to more clearly communicate complex healthcare performance, enabling consumers to make good and effective use of this information, as has been demonstrated by healthcare consumer satisfaction surveys like the national Hospital Consumer Assessment of Healthcare Providers and Systems survey (HCAHPS).

        ii. Recognizing too that there are many modes of delivery of this information, the CAC should be directed to make this information available in many formats (paper, web-based, and other electronic formats) for ready accessibility to the general public. One example of a web-based format is sponsored by the state of Florida on their www.FloridaHealthFinder.gov internet site, providing information for both consumers and healthcare professionals.

        iii. Identify partner organizations with existing communication vehicles to better promote distribution and effective use of this information.

iv. Explore new types of distribution channels utilizing employers, insurers, points of care, public agencies, etc.

c. Iowa healthcare providers must continue to use industry techniques to improve the efficiency and effectiveness of healthcare. Iowa healthcare providers must continue using data to benchmark improvements in the process of care which use Lean or other effective process improvement practices. While private industry has used process improvement techniques for years, healthcare is making greater use of these techniques to improve both effectiveness as well as clinical care. Data is critical to making these improvements in healthcare delivery.

d. Efforts should be made to analyze and include emerging measures of efficiency to inform and support the development of a sustainable healthcare system. The CAC can provide important input into this work for Iowans.

3. **IHC should be encouraged to evaluate collection of additional healthcare provider specific data**.[15] Most publicly available healthcare data is hospital-centric. Delivery of healthcare in physician offices is not systematically available, yet represents the majority of where healthcare is delivered. IHC shall continue to work with the advisement of the CAC to explore additional healthcare provider specific data. Two specific provider-led recommendations are made as follows:

   a. IHC should explore the feasibility of development of a physician all-payer database. With this data and analysis available, more work can occur in partnership with physicians to enable improvements in the delivery of care.

   b. Additionally, IHC reporting should take a specific focus on variations in the delivery of care to enable hospitals and physicians to benchmark their performance against other providers of care and understand where improvements can be made in order to improve quality overall.

4. **Promote the Patient Centered "Medical Home" model of care in Iowa**. "A medical home…is a physician-directed practice that provides care that is 'accessible, continuous, comprehensive, and coordinated and delivered in the context of family and community.'" [16] Iowa's existing healthcare provider population is challenged in the number of medical specialists practicing within our borders. Additionally, our performance is highest in the primary care area of care delivery. The medical home model best meets Iowa's access to care, wellness, and prevention challenges for the future. House File 2539 also authorized the identification of a Medical Home Work Group, whose focus is to identify the building blocks of a medical home strategy in Iowa. Additionally, opportunities exist for Iowa to benefit from a national medical home demonstration project, funded by the Centers for Medicare and Medicaid Services (CMS). This

15 IHC is not the only organization in Iowa collecting data.
16 Berenson RA, Hammons T, et.al., "A House is not a Home: Keeping Patients at the Center of Practice Design", Health Affairs Sep/Oct 2008, 27:5 (p. 1219)

demonstration will encourage physicians and clinics to become certified by the National Committee on Quality Assurance (NCQA) as medical homes. NCQA certification requires practices to utilize healthcare information technologies (such as electronic medical records, electronic health records, electronic databases) that can be used to manage patients appropriately to assist providers in caring more effectively for each patient. This certification will also enable them to benefit from enhanced reimbursement from serving Medicare patients, and will also equip them to more effectively manage the continuum of care for Iowans. This will result in improved service, care coordination, and chronic care management for all Iowans. While federal funds are available to encourage physicians to achieve the designation, IHC aims to provide support to physicians in developing their understanding of the requirements, and enabling their effective execution of this strategy.

5. **Health information technology (HIT) is a fundamental building block of the national strategy to promote healthcare transparency.** As HIT implementation lags nationally and in Iowa, this fact hinders the state's ability to promote transparency, and as importantly, to encourage data-based improvement efforts around evidence-based medical practices and in promoting the efficient delivery of care. Two action items are proposed:

    a. Elimination of infrastructure barriers, such as lack of a unique patient identifier and standardization of technology platforms, will promote interoperability of the system, improving both the cost and quality of care. Iowa leaders should also interact with federal officials to promote national solutions such as the promotion of a national standard patient identifier to assist in tracking episodes of care. This will enable providers to better understand patient experiences across healthcare venues, so they can be more effectively managed. This is a necessary component to achieve the health improvement benefits promised in the PCMH model.

    b. State government, working with the federal government, should support the development of information technology to automate the collection and analysis of cost and quality data to reduce the burden of collection on reporting entities.

    c. State government should also strongly consider tax incentives for physicians who invest in health information technology.

Appendix

Table 1. States Collecting and Publicly Reporting Hospital Data

State	State Mandate	Inpatient Data	Ambulatory Surgery Data	Emergency Department Data
Alabama				
Alaska	No	Voluntary		
Arizona	Yes	Mandatory	Mandatory	Mandatory
Arkansas	Yes	Mandatory		
California	Yes	Mandatory	Mandatory	Mandatory
Colorado	No	Voluntary	Voluntary	
Conneticut	Yes	Mandatory	Voluntary	Voluntary
Delaware	Yes	Mandatory		
D. C.	Yes	Voluntary	Status Uncertain	Status Uncertain
Florida	Yes	Mandatory	Mandatory	Mandatory
Georgia	Yes	Mandatory	Mandatory	Mandatory
Hawaii	No	Voluntary	Voluntary	Voluntary
Idaho				
Illinois	Yes	Mandatory	Mandatory	
Indiana	Yes	Mandatory	Mandatory	Mandatory
IOWA	**Yes**	**Mandatory**	**Mandatory**	**Mandatory**
Kansas	Yes	Voluntary	Voluntary	Voluntary
Kentucky	Yes	Mandatory	Mandatory	
Louisiana	Yes	Mandatory		
Maine	Yes	Mandatory	Mandatory	Mandatory
Maryland	Yes	Mandatory	Mandatory	Mandatory
Massachusetts	Yes	Mandatory		Mandatory
Michigan	No	Voluntary	Voluntary	
Minnesota	Yes	Voluntary	Voluntary	Voluntary
Mississippi	Yes	Mandatory		
Missouri	Yes	Mandatory	Voluntary	Mandatory
Montana	No	Voluntary		
Nebraska	No	Voluntary	Voluntary	Voluntary
Nevada	Yes	Mandatory		
New Hampshire	Yes	Mandatory	Mandatory	Mandatory
New Jersey	Yes	Mandatory	Mandatory	Mandatory
New Mexico	Yes	Mandatory		
New York	Yes	Mandatory	Mandatory	Mandatory
North Carolina	Yes	Mandatory	Mandatory	
North Dakota	Yes			
Ohio	No	Voluntary	Voluntary	Voluntary
Oklahoma	Yes	Mandatory	Mandatory	
Oregon	Yes	Mandatory		
Pennsylvania	Yes	Mandatory	Mandatory	
Rhode Island	Yes	Mandatory		Mandatory
South Carolina	Yes	Mandatory	Mandatory	Mandatory
South Dakota	No	Voluntary	Voluntary	Voluntary
Tennessee	Yes	Mandatory	Mandatory	Mandatory
Texas	Yes	Mandatory		
Utah	Yes	Mandatory	Mandatory	Mandatory
Vermont	Yes	Mandatory	Voluntary	Voluntary
Virginia	Yes	Mandatory	Mandatory	
Washington	Yes	Mandatory		
West Virginia	Yes	Mandatory		
Wisconsin	Yes	Mandatory	Mandatory	Mandatory
Wyoming	No	Voluntary		
	"Yes"	"Mandatory"	"Mandatory"	"Mandatory"
Totals	**40**	**36**	**21**	**18**

Sources: Summary of Health Care Reporting For Member of the National Association of Health Data Organizations (NAHDO); Retrieved 10/7/2008 at http://nahdo.org/cs/media

Table 2. States Collecting and Publicly Reporting AHRQ / CMS Measures

State	AHRQ Quality Indicators - Outcome Measures	CMS / HQA - Process Measures
Alabama		x
Alaska		x
Arizona		x
Arkansas		x
California	x	x
Colorado	x	x
Conneticut		x
Delaware		x
D. C.		x
Florida	x	x
Georgia		x
Hawaii		x
Idaho		x
Illinois		x
Indiana		x
IOWA	**x**	**x**
Kansas		x
Kentucky	x	x
Louisiana		x
Maine		x
Maryland		x
Massachusetts	x	x
Michigan		x
Minnesota		x
Mississippi		x
Missouri		x
Montana		x
Nebraska		x
Nevada		x
New Hampshire		x
New Jersey	x	x
New Mexico		x
New York	x	x
North Carolina		x
North Dakota		x
Ohio	x	x
Oklahoma		x
Oregon	x	x
Pennsylvania		x
Rhode Island		x
South Carolina		x
South Dakota		x
Tennessee		x
Texas	x	x
Utah	x	x
Vermont	x	x
Virginia		x
Washington		x
West Virginia		x
Wisconsin	x	x
Wyoming		x
	"x"	"x"
Totals	**14**	**51**

Sources: Agency for Healthcare Research and Quality. Key Choices in Analyzing Data; Quality Indicator Learning Institute (QILI), Presented at QILI Webinar, December 15, 2008.

Table 3. States Collecting and Publicly Reporting Serious Reportable Events / "Never Events"

State	"Never" Events	Never Events - Quantity Reported
Alabama		
Alaska		
Arizona		
Arkansas		
California	x	
Colorado	x	10
Conneticut	x	28
Delaware		
D. C.		
Florida	x	8
Georgia	x	
Hawaii		
Idaho		
Illinois	x	24
Indiana	x	
IOWA ***	**see note**	**see note**
Kansas	x	see note
Kentucky		
Louisiana		
Maine	x	7
Maryland	x	
Massachusetts	x	16
Michigan		
Minnesota	x	28
Mississippi		
Missouri		see note
Montana		
Nebraska		
Nevada	x	
New Hampshire		
New Jersey	x	29
New Mexico		
New York	x	32
North Carolina		
North Dakota		
Ohio	x	9
Oklahoma		
Oregon	x	25
Pennsylvania	x	
Rhode Island	x	7
South Carolina	x	
South Dakota	x	4
Tennessee	x	34
Texas	x	
Utah	x	38
Vermont		
Virginia		
Washington	x	
West Virginia		
Wisconsin		
Wyoming		
	"x"	
Totals	**25**	

Sources: National Academy for State Health Policy. Retrieved 10/9/2008 at http://www.nashp.org/_docdisp_page.cfm?LID=2A789909-5310-11D6-BCF000A0CC558925.

Other Notes: Iowa Never Events - IHC publicly reports 2 AHRQ PSIs that correspond to "Never Events" - Foreign Body Left in During Procedure, Transfusion Reaction (wrong blood type).

Iowa Hospital Association urges Iowa hospitals to refrain from billing patients for 8 NQF "Serious Adverse Events".

Kansas Never Events - Has legislation (1986) that establishes adverse event reporting, but does not specifically list types of adverse events to be reported.

Missouri Never Events - the Missouri Hospital Associaton urges Missouri's hospitals to refrain from billing patients for 28 NQF "Serious Adverse Events".

Missouri's Anthem Blue Cross and Blue Shield - no pay at all for 3 "never events". Only appropriate payment for 8 "never events".

Table 4. States Collecting and Publicly Reporting Healthcare-associated Infection Measures

State	Surgical	Central-Line / Device - related / Bloodstream	Ventilator - Associated Pneumonia (VAP)	Catheter-associated Urinary Tract Infections	Healthcare Worker Influenza Vaccination	MRSA Infections	CMS - Surgical Care Infection Prevention Process Measures
Alabama							x
Alaska							x
Arizona							x
Arkansas							x
California					x	x	x
Colorado	x	x					x
Conneticut						x	x
Delaware							x
D. C.							x
Florida							x
Georgia							x
Hawaii							x
Idaho							x
Illinois	x	x	x			x	x
Indiana							x
IOWA * **	**x**	**x**			**x**	**x**	**x**
Kansas							x
Kentucky							x
Louisiana							x
Maine		x					x
Maryland	x	x			x	x	x
Massachusetts	x	x					x
Michigan							x
Minnesota						x	x
Mississippi							x
Missouri	x	x	x				x
Montana							x
Nebraska							x
Nevada							x
New Hampshire	x	x	x		x		x
New Jersey						x	x
New Mexico							x
New York	x	x	x				x
North Carolina							x
North Dakota							x
Ohio							x
Oklahoma		x	x				x
Oregon	x	x					x
Pennsylvania	x	x	x	x		x	x
Rhode Island	x	x	x	x			x
South Carolina	x	x	x				x
South Dakota							x
Tennessee	x	x				x	x
Texas	x	x					x
Utah							x
Vermont	x	x					x
Virginia		x					x
Washington	x	x	x				x
West Virginia							x
Wisconsin							x
Wyoming							x
	"x"	"x"	"x"	"x"	"x"	"x"	"x"
Totals	**16**	**19**	**9**	**2**	**4**	**9**	**51**

Sources: Consumers Union. StopHospitalInfections.org, Retrieved 10/2/2009 at http://www.stophospitalinfections.org/learn.html
Government Accountability Office (GAO). Healthcare-associated Infections in Hospitals: An Overview of State Reporting Programs and Individual Hospital Initiatives to Reduce Certain Infections. September, 2008;GAO-08-808.

*** Iowa Note: Although the HAI data in this table represents states' mandated efforts, Iowa's voluntary efforts are included here for comparison purposes.

Table 5. States Collecting and Publicly Reporting Finance / Cost / Charge Information

State	Require all health care providers to report data	Require only hospitals to report data	At least some financial information made public via website	Charges - Price Point Software / Website
Alabama				
Alaska				
Arizona			x	x
Arkansas			x	
California			x	
Colorado				
Conneticut				
Delaware				
D. C.				
Florida	x		x	
Georgia				x
Hawaii				
Idaho				
Illinois			x	
Indiana		x	x	
IOWA				**x**
Kansas	x			
Kentucky				
Louisiana				
Maine	x		x	
Maryland			x	
Massachusetts	x		x	
Michigan				
Minnesota		x	x	
Mississippi	x			
Missouri	x			
Montana				
Nebraska				x
Nevada			x	x
New Hampshire			x	x
New Jersey		x		
New Mexico				x
New York			x	
North Carolina				
North Dakota				
Ohio		x		
Oklahoma	x		x	x
Oregon			x	x
Pennsylvania			x	
Rhode Island			x	x
South Carolina			x	
South Dakota		x		
Tennessee			x	
Texas			x	x
Utah	x		x	x
Vermont		x	x	
Virginia	x		x	x
Washington			x	x
West Virginia			x	
Wisconsin	x		x	
Wyoming				
	"x"	"x"	"x"	"x"
Totals	**10**	**6**	**26**	**14**

Sources: Iowa Hospital Association