HPD Public Reporting: Principles and Priorities

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For Today

- Background on APCD public reporting strategy
- Principles to guide HPD public reporting
- Prioritization criteria for public reporting topics
- Prioritizing among public reporting topics

Background on APCD Public Reporting Strategy

Reporting Principles Background

- Overarching reporting principles can be stated in legislation/regulation or can evolve as the database matures

- APCDs vary in evolving their reporting programs
  - Fulfilling specific legislative directives
  - Obtaining stakeholder input to refine legislative guidance
  - Building reports as needed to guide policy development
  - *Ad hoc* analyses in response to emerging issues

Enabling Statutes & Public Reporting Authority

Legislative direction is essential to drive use of the APCD for public reporting.

Connecticut: “The purpose of the APCD is to make available information related to safety, quality, cost-effectiveness, transparency, access and efficiency for all levels of health care to improve the health of Connecticut’s residents at all levels of health care delivery.”

Colorado: “Reporting of health care and health quality data that results in transparent and public reporting of safety, quality, cost, and efficiency information; and analysis of health care spending and utilization patterns for purposes that improve the population's health, improve the care experience, and control costs.”

Legislatively Required/Authorized Reports

Enabling statutes mix general authority and specific topics

- New Hampshire – provide a consumer facing website
- Massachusetts – support cost trends monitoring
- Minnesota – provide reports on specific topics
- Oregon – primary care spending

Public Reporting Priorities Evolve Over Time

- Initial Public Reporting Topics
  - Straightforward and less controversial reports
  - Demonstrate APCD capabilities, builds awareness and trust
  - Examples: Variation in cost, utilization, chronic disease prevalence, access
- More Advanced Public Reporting Topics
  - More complex analytics
  - May need supplemental data
  - May need supplemental tools
  - May need provider previews
  - Examples: Episodes of care, provider/payer specific reporting, primary care spending, total cost of care

Avenues for Principles to Evolve

- Stakeholder Input
  - Washington – Annual Reporting Plan
  - Connecticut – Report to APCD Advisory Committee
  - Colorado Advisory Committee – General oversight of reports and feedback during meetings
- Agency Mission or Priority-Driven
  - Delaware – Total Cost of Care
  - Grant Funded Projects:
    - Robert Wood Johnson Foundation/Peterson Foundation – Total Cost of Care
    - Maine, Virginia, Colorado, Washington – Low Value Care

Reporting Information that may be Considered Sensitive

- Defined as: the combination of Payer and/or Provider Name with Allowed Amount (sum of insurer paid plus patient paid)
- Major focus of concerns about public reporting
- Examples of how addressed
  - Minnesota: Payer and Provider Names never published
  - New York: Initial reports show aggregated data across payers and health plan products.
  - Colorado: Consideration of Federal Trade Commission/Department of Justice Statement 6 provisions
  - CMS/Qualified Entity Certification Program: Combine Medicare data with commercial data

Principles for Reporting Information that may be Considered Sensitive: Examples

- CMS Qualified Entity Certification Program
  - Use National Quality Forum certified or CMS approved measures
  - Establish standards for public reports, e.g., at least 30 observations
  - Transparency on methodology
  - Mandatory Corrections and Appeals process

- New York State Price Transparency Workgroup
  - Data support what is being measured
  - Actionable for policymakers and those being measured
  - Adjusted for severity, where appropriate
  - Broadly representative and meaningful

California’s Opportunity

- California’s Report to the Legislature synthesized APCD experience into a consolidated set of principles
- Upfront diverse stakeholder input supports expeditious public reporting rollout
- Nimble public reporting strategies allow the database to provide timely key insights

Resources

Statements of purpose

Connecticut: https://portal.ct.gov/-/media/OHS/Health-IT-Advisory-Council/APCD-Advisory-Group/Presentations/OHS_APCD-Advisory-Group_Meeting-Presentation_051321.pdfs (Slide 16)

Colorado: https://www.civhc.org/wp-content/uploads/2021/02/SB-13-149.pdf (SB 13-149)

Methodologies and approaches

Massachusetts Center for Health Information and Analytics Strategy for Releasing Procedure Price Data: https://www.chiamass.gov/assets/Uploads/Strategy-for-Releasing-Procedure-Pricing-Data.pdf

Minnesota Report to the Legislature: https://www.health.state.mn.us/data/apcd/docs/APCDwkgrpFinalRpt2015Jan.pdf

New York State Department of Health Price Methodology Workgroup: https://uhfnyc.org/media/filer_public/e7/4c/e74c6be6-06e6-4e82-84b1-85aee0250479/nys_doh_pmw_final_recommendations_report_uhf_20210406-b.pdf

Washington APCD Annual Reports to be produced in 2021: https://www.hca.wa.gov/assets/program/WA-APCD-public-comment-2021-02-05.pdf

Public Reporting: Principles

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Principles vs. Priorities

Principles

- Principle: a comprehensive and fundamental law, doctrine, or assumption
- APCD public reporting context: agreed-upon “rules of the road” to follow when reporting results based on APCD data

Priorities (Topics)

- Priority: something given or meriting attention before competing alternatives
- APCD public reporting context: allocation of limited resources to higher-priority analytic topics

Source for definitions: Merriam-Webster.com

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“Lessons from the Front Lines” in California

- Multi-Payer Claims Data Collection in California – panel presentations to inform HPD, May 2019 Review Committee meeting
  - Integrated Healthcare Association
  - Purchasers Business Group on Health
  - Covered California
- Key Takeaways:
  - Importance of alignment with existing measure standards
  - Importance of stakeholder engagement
  - Expand data and reporting capabilities over time; phase in use cases

Public Reporting Principles for the HPD

1. Protect Patient Privacy

- Protect from reidentification with prohibitions on publishing direct identifiers and guidelines such as safe harbor, small cell size suppression, geographic representation, and age bands.

2. Adopt Methods that Ensure Validity

- Use only methods that can be supported by the data and techniques that produce reliable and stable results over time.
- Use best practices when creating comparisons, including factors such as appropriate sample sizes, meaningful variation, risk adjustment, and statistical validity.

3. Align with Existing Efforts

- Use nationally accepted, standardized measures.
- Consider measurement efforts underway in California and nationally.

4. Engage Stakeholders in the Process

- Incorporate stakeholder perspectives into priority-setting for public reporting.
- When appropriate, preview the results with affected stakeholders prior to publication.

5. Inform Policy and Practice

- Generate information that is meaningful, relevant, and actionable.
- Deliver findings that are understandable and accessible to diverse audiences.

6. Provide Documentation for Users of Data and Data Products

- Provide information about attribution techniques and results.
- Disclose the statistical basis for the analysis and provide documentation.

Discussion Questions

- Considering each principle, what detail should be added (or eliminated) to ensure the key information is captured?
- Any additional principles that should be considered?
- Any principles that don't belong on the list?

Public Reporting: Priorities

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HPD: Legislative Intent

- Greater **transparency** regarding health care costs, utilization, quality, and equity
- Information is used to **inform policy decisions** regarding the provision of quality health care, improving public health, reducing disparities, advancing health coverage, reducing health care costs, oversight of the health care system and health care companies, and providing **public benefit** for Californians and the state, while preserving **consumer privacy**
- Improve data transparency to achieve a **sustainable health care system** with more equitable access to **affordable and quality health care for all**
- Use the data to develop innovative approaches that have the potential to deliver **health care that is both cost effective and responsive to the needs of enrollees** including recognizing the **diversity of California and the impact of social determinants of health**

Health and Safety Code Section 127671

Reporting Required by Enabling Statute

- Annual report showing, at a minimum (HSC Section 127673.7):
  - Population and regional level data on:
    - prevention, screening, and wellness utilization
    - chronic conditions, management, and outcomes
    - trends in utilization of procedures for treatment of similar conditions to evaluate medical appropriateness
  - Regional variation in payment level for the treatment of identified chronic conditions.
  - Data regarding hospital and nonhospital payments, including inpatient, outpatient, and emergency department payments and nonhospital ambulatory service data.
- Other one-time reports required, e.g. summary report on data submitted; report on data quality and improvement processes

Potential Public Reporting Priorities

Sooner

"Simple" Statistics

- Initial cost and utilization statistics, statewide and:
  - By geography, age, gender
  - By payer (Medi-Cal, Medicare, commercial)
- Component cost and utilization (e.g., inpatient, outpatient, professional, prescription drug)
- Out of pocket costs
- Chronic conditions by geography and payer, age and gender
- COVID-19 utilization, cost

Next

Increasing Complexity

- Increasingly robust cost and utilization statistics
- Cost for common episodes of care/procedures
  - By care setting, provider
- Health disparities (race/ ethnicity Census overlay)
- Low value care: sources volume, cost
- Chronic conditions: costs to treat, utilization
- Prescription drug spending
- Primary care spending
- Behavioral health utilization

Longer-Term

Supplemental Data

- Prevalence of capitation and alternative payment models
- Statewide health system performance
- Total cost of care
- Provider comparisons on cost and quality
- Primary care spending (incl non-claims payments)
- Behavioral health spending (incl non-claims payments)
- Enhancing race/ethnicity/ language reporting through linkage to other sources

Reminder: Limitations and Challenges

Exclusions from the data

- Self-insured private plans
  - HPD can accept data but not mandate submission
- Uninsured
- Federal employees
- Prison system
- Active military, Veterans Affairs, TRICARE
- Indian Health Service

Challenges

- Lag in reporting / timeliness
- Encounter data quality
- Data completeness
- Maximizing use of existing administrative data (not collected for APCD use)
- Not easy! Especially for California – enormous population, massive amount of data

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Initial Public Reporting Priorities

Sooner

"Simple" Statistics

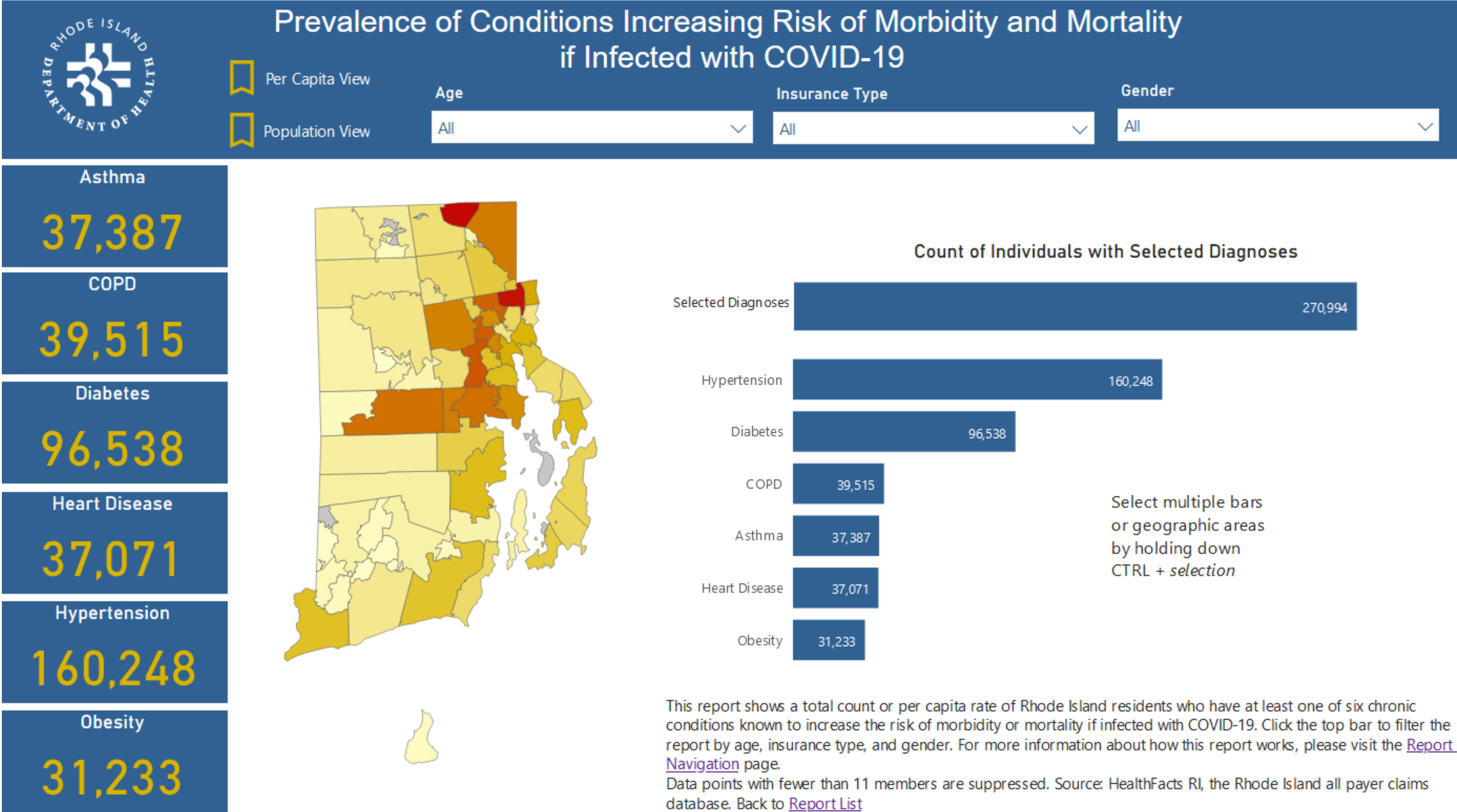
- Initial cost and utilization statistics, statewide and:
  - By geography, age, gender
  - By payer (Medi-Cal, Medicare, commercial)
- Component cost and utilization (e.g., inpatient, outpatient, professional, prescription drug)
- Out of pocket costs
- Chronic conditions by geography and payer, age and gender
- COVID-19 utilization, cost

- Starting place: relatively straightforward summary statistics, limited to analysis that can be supported by early data
- Lays the foundation for future analysis and reporting
- Specifics will be developed with the APCD platform vendor
- Largely aligns with required annual reporting

Condition Prevalence

About this analysis:

- Uses diagnosis codes to identify patients with these conditions
- Counts unique individuals
- Does not require a longitudinal analysis of claims, costs or utilization



Source:
RI Report on COVID-19 Comorbidities

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Second-Tier Public Reporting Priorities

Next

Increasing Complexity

- Increasingly robust cost and utilization statistics
- Cost for common episodes of care/procedures
  - By care setting, provider
- Health disparities (race/ ethnicity Census overlay)
- Low value care: sources, volume, cost
- Chronic conditions: costs to treat, utilization
- Prescription drug spending
- Primary care spending
- Behavioral health utilization

- Builds on groundwork laid in early analysis and public reporting
- May require analytic tools (e.g. episode groupers, therapeutic classifications for Rx), additional data (e.g. Census)
- Specifics will be developed with the APCD platform vendor

Chronic Conditions

- Select chronic conditions for reporting
- Build on prevalence by adding utilization and cost

Chronic Condition

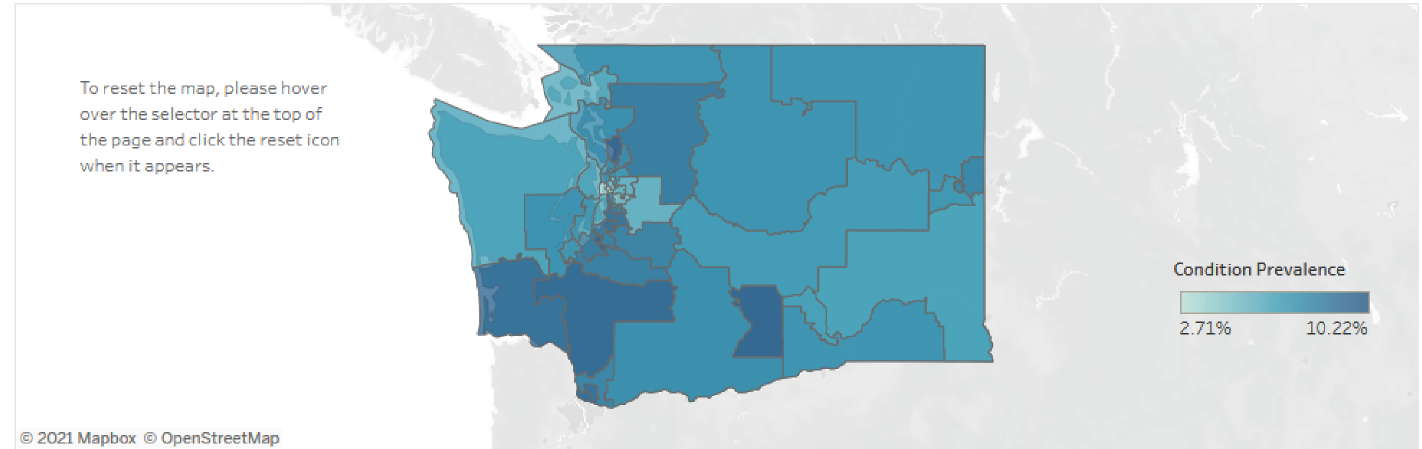
Diabetes

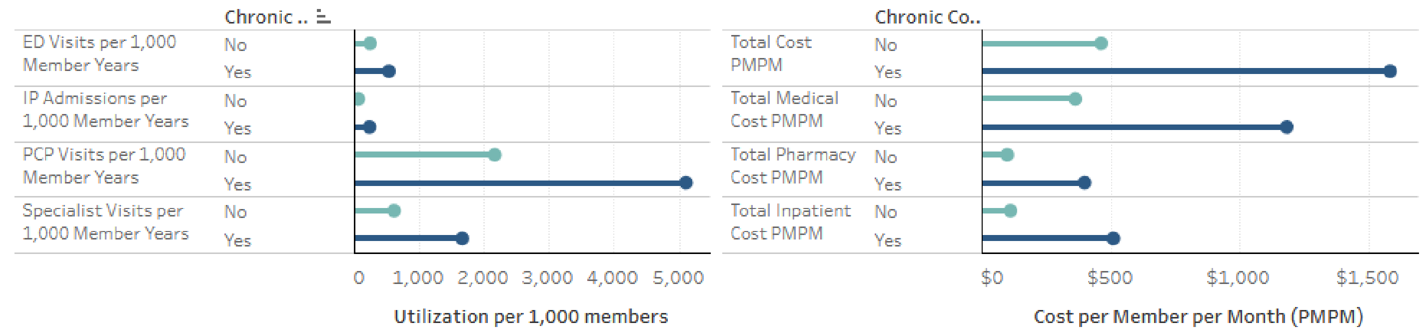
- ADHD
- Asthma
- Breast Cancer
- Congestive Heart Failure
- COPD
- Depression
- Diabetes
- Heart Disease
- Hypertension
- Stroke

Prevalence of Chronic Conditions in Washington State

Measurement Year	Chronic Condition	Map
2017	Diabetes	Legislative District

2017 Prevalence of Members with Diabetes	Difference in Diabetes Prevalence 2016 - 2017	2017 Total Cost PMPM for Members with Diabetes	Diff. in Total Cost PMPM for Members Diabetes 2016 - 2017
7.50%	0.42%	$1,584.77	$-97.94





Source: Washington State APCD

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Future Public Reporting Priorities

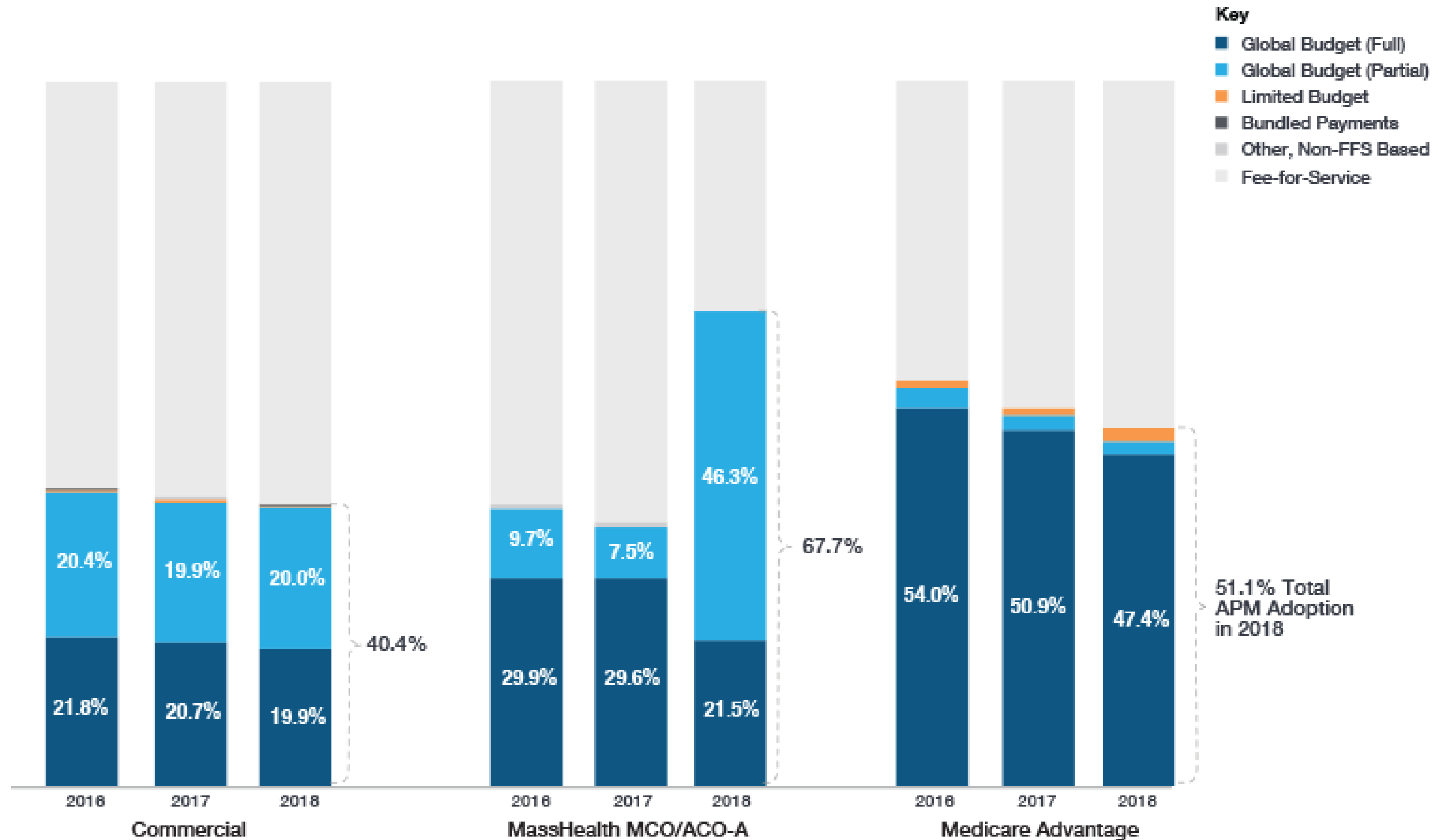
Longer-Term

Supplemental Data

- Prevalence of capitation and alternative payment models
- Statewide health system performance
- Total cost of care
- Provider comparisons on cost and quality
- Primary care spending (incl non-claims payments
- Behavioral health spending (incl non-claims payments)
- Enhancing race/ethnicity/ language reporting through linkage to other sources

- Non-claims data is essential to include in HPD but will require supplemental data collection (e.g. capitation, APM, pharmacy rebates) – no national standard yet available
- Statewide health system performance requires reporting on multiple/many aspects and will build over time
- Comparative reporting on identified entities requires a more extensive process
- Data linkages are promising but complex and challenging

Adoption of Alternative Payment Methods by Insurance Category, 2016-2018



Notes: MassHealth=Medicaid

Source: Performance of the Massachusetts Health Care System, Annual Report, October 2019

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Prioritization Criteria for Public Reporting Topics

1. **Supports the Legislative Intent of the Program**
   - Transparency on cost, utilization, quality, equity
   - Inform policy decisions, provide public benefit while preserving consumer privacy
   - Contribute to sustainable system that provides equitable access to affordable and quality health care
   - Contribute to care delivery that is cost effective and responsive to the needs of enrollees, recognizing diversity and the impact of social determinants of health
2. **Meets Statutory Requirements**
   - Required annual reports
   - Required one-time reports
   - Receive Advisory Committee input on priorities
3. **Produces Results Relevant to Policy and/or Practice**
   - Responsive to legislative and administration priorities
   - Responsive to emerging health care and public health needs
   - Responsive to stakeholder feedback
4. **Is Feasible to Produce with Available Data and Resources**
   - Data availability, quality, timeliness, and appropriateness
   - Endorsed and defined measure definitions
   - Staff availability and experience

The office shall use the program data to produce publicly available information, including data products, summaries, analyses, studies, and other reports, to support the goals of the program. The office **shall receive input on priorities** for the public information portfolio from the **advisory committee.** (Section 127673.8.(a))

Discussion Questions

- Considering each criterion, what detail should be added (or eliminated) to ensure the key information is captured?
- Any additional criteria that should be considered?
- Any criteria that don't belong on the list?

Prioritization of Second-Tier Topics

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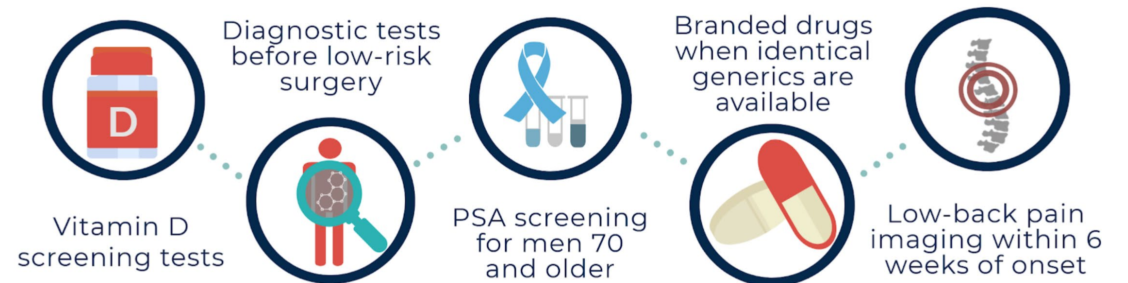
Tier 2 Topics Feature Increasing Complexity

- Increasingly robust cost and utilization statistics
- Low Value Care
- Costs for common episodes of care / procedures (by geography, payer, age, care setting)
- Health Disparities (race/ethnicity Census overlay)
- Chronic conditions: costs to treat, utilization
- Prescription Drug Spending
- Primary Care Spending
- Behavioral Health Spending

Example: Low Value Care

Low-Value Care

- Why does it matter?
  - Reduce overuse and associated cost, increase affordability
  - Improve quality by reducing unnecessary care
- Identifying "low-value" care
  - Choosing Wisely™ (ABIM Foundation)
  - U.S. Preventive Services Task Force
  - Task Force on Low-Value Care's "Top Five"



- Tools and Analytics
  - Milliman's MedInsight Health Waste Calculator tool often used
  - HPD approach would be developed with the APCD platform vendor

Sources: Building a Better Health Care System Post-Covid-19: Steps for Reducing Low-Value and Wasteful Care, Sorenson et al, NEJM Catalyst, April 2020; Tackling Low-Value Care: A New "Top Five" for Purchaser Action, Buxbaum et al, Health Affairs Blog, November 2017, Center for Value-Based Insurance Design at the University of Michigan

Four-State Study of Low Value Care

- Quantify utilization and spending on 47 low-value care services
- Data from APCDs in four states analyzed using Milliman MedInsight Health Waste Calculator
- Three years of data, 2014-2017
- Total spend on “top 10” low value services in 2017 in the four states was $667 million for Medicaid and commercial markets

Source: Utilization and Spending on Low-Value Medical Care Across Four States, VBID Health, May 2020

Spending on “Top 10” Commercial and Medicaid Low-Value Services by Volume in 2017

For each of the four states, the ten most frequently provided LVC services by volume in commercial and Medicaid sectors were identified and related spending calculated (Table 4).

Table 4. Low-Value Spending on Top 10 services by Volume, in 2017

2017	Total Spend on "Top 10" LVC Services	PMPM	% Total Medicaid and Commercial Waste Spending
Maine	$49,659	$6.67	78%
Washington*	$278,236	$8.69	80%
Colorado	$160,125	$5.65	73%
Virginia	$179,322	$4.37	68%
Total	$667,343	$6.13	70%

*Notes: total spending in thousands $. PMPM = total spending on the top 10 services divided by total member months (Appendix 3) provided by the states for 2017. These data only include Medicaid and commercial spending. *Washington did not separately report patient and plan spending, and estimated total spending based on standard pricing for Medicaid and commercial plans.*

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Discussion Questions

Increasingly robust cost and utilization statistics

Low Value Care

Costs for common episodes of care / procedures (by geography, payer, age, care setting)

Health Disparities (race/ethnicity Census overlay)

Chronic conditions: costs to treat, utilization

Prescription Drug Spending

Primary Care Spending

Behavioral Health Spending

- What input do you have for OSHPD on initial second-tier reporting priorities for HPD?
- Among the possibilities listed:
  - What is most important, and why?
  - What is least important, and why?
  - What is missing?