Establishment of General Principles and Priorities for HPD Public Reporting

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For Today

- Continue discussion started in July
- Revisit principles to guide HPD public reporting – incorporating feedback received
- Prioritization criteria for public reporting topics
- Public reporting priorities – early considerations and input

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APCDs Generally Specify Tiers of Data Use

Publicly Available

- De-identified, aggregate data
- Data products (analyses, reports, data sets) posted on APCD website
- Process to request custom analysis and reports to be developed

Non-Public Access by Application

- Potentially identifiable data (no direct patient identifiers)
- Intention to create a data enclave to facilitate access through a secure environment
- Requires formal application/review, data use agreement

Researcher Access by Application

- Identifiable data (could include direct patient identifiers)
- Intention to create a data enclave to facilitate access through a secure environment
- Requires approval from CHHS IRB and formal application/review, data use agreement

Public Reporting: Principles

Public Reporting Principles for the HPD - Original

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.

New Federal Rules To Increase Transparency

- Hospital transparency rule went into effect 1/1/2021
  - Requires public release of negotiated rates for all items and services with a standard charge
  - Rule upheld against lawsuit challenge
  - Compliance mixed to date; July 2021 executive order aims to increase compliance, strengthen enforcement
  - Available information indicates substantial variation
- Insurance transparency rule implementation to be phased in 2022-2024
  - Requires public release of negotiated rates with in-network providers for all covered items/services – effective 7/1/2022
  - Requires public release of billed charges and allowed amounts for covered items/services provided by out of network providers – effective 7/1/2022
  - Lawsuits filed to challenge these two requirements in August 2021
  - Rule also requires public release of prescription drug negotiated rates and historical net prices for in-network providers, but enforcement deferred

Source: Health Affairs blogs 8/25/2021, 8/16/2021, 1/19/2021; NYT article 8/22/2021

ORIGINAL (JULY VERSION)	REVISED (AND REORDERED)
1. Protect Patient Privacy	**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.	• Protect patient-level data from reidentification with prohibitions on publishing direct identifiers. • Follow guidelines such as CHHSA data-deidentification and HIPAA safe harbor.
2. Adopt Methods that Ensure Validity	**4. Adopt Methods that Ensure Credibility**
• 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.	• Use only methods that can be supported by the data and techniques that produce reliable and stable results over time, acknowledging the limitations of data collected for other purposes (primarily billing). • 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	**5. Align with Existing Efforts**
• Use nationally accepted, standardized measures. • Consider measurement efforts underway in California and nationally.	• When available and appropriate, use nationally accepted, standardized measures. • Consider measurement efforts underway in California and nationally. • Coordinate with other relevant state agencies.
4. Engage Stakeholders in the Process	**3. 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.	• 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	**2. Inform Policy and Practice**
• Generate information that is meaningful, relevant, and actionable. • Deliver findings that are understandable and accessible to diverse audiences.	• Generate information that is accurate, meaningful, relevant, actionable, and as comprehensive as possible. • Consider the needs of diverse audiences, and design public information products that meet those needs. • Consider ways to mitigate the risk of anticompetitive behavior when publicly reporting data.
6. Provide Documentation for Users of Data and Data Products	**6. Provide Information to Support User Understanding**
• Provide information about attribution techniques and results. • Disclose the statistical basis for the analysis and provide documentation.	• Include information about data sources, methodology, and limitations with public information products. • To the extent possible, use language understandable to diverse audiences.

Public Reporting Principles for the HPD - Revised

1. Protect Patient Privacy

- Protect patient-level data from reidentification with prohibitions on publishing direct identifiers.
- Follow guidelines such as CHHSA data-deidentification and HIPAA safe harbor.

2. Inform Policy and Practice

- Generate information that is accurate, meaningful, relevant, actionable, and as comprehensive as possible.
- Consider the needs of diverse audiences, and design public information products that meet those needs.
- Consider ways to mitigate the risk of anticompetitive behavior when publicly reporting data.

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- Incorporate stakeholder perspectives into priority-setting for public reporting.
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- When available and appropriate, use nationally accepted, standardized measures.
- Consider measurement efforts underway in California and nationally.
- Coordinate with other relevant state agencies.

6. Provide Information to Support User Understanding

- Include information about data sources, methodology, and limitations with public information products.
- To the extent possible, use language understandable to diverse audiences.

Public Reporting: Prioritization Criteria

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

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. **Is Feasible to Produce with Available Data and Resources**
   - Data availability, quality, timeliness, and appropriateness
   - Availability of analytic requirements, including tools and measure definitions
   - Staff availability and experience
4. **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

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?

Public Reporting: Priorities

Framework for 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 condition prevalence 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
- Quality of care
- 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

- ERISA self-funded 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

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 condition prevalence 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 Onpoint, the APCD platform vendor
- Align 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

Prevalence of Conditions Increasing Risk of Morbidity and Mortality if Infected with COVID-19

Per Capita View

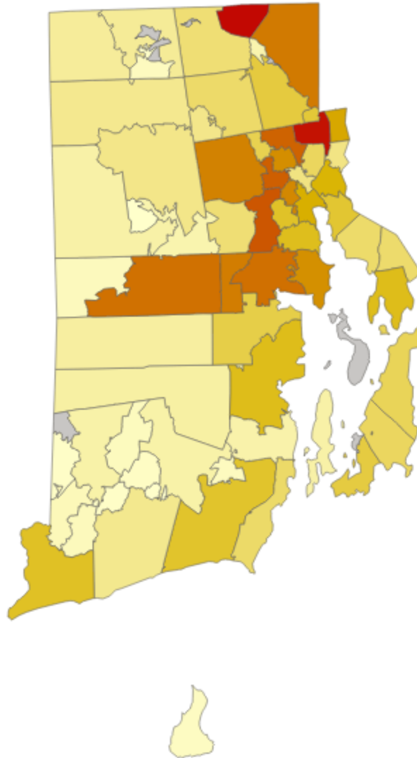
Population View

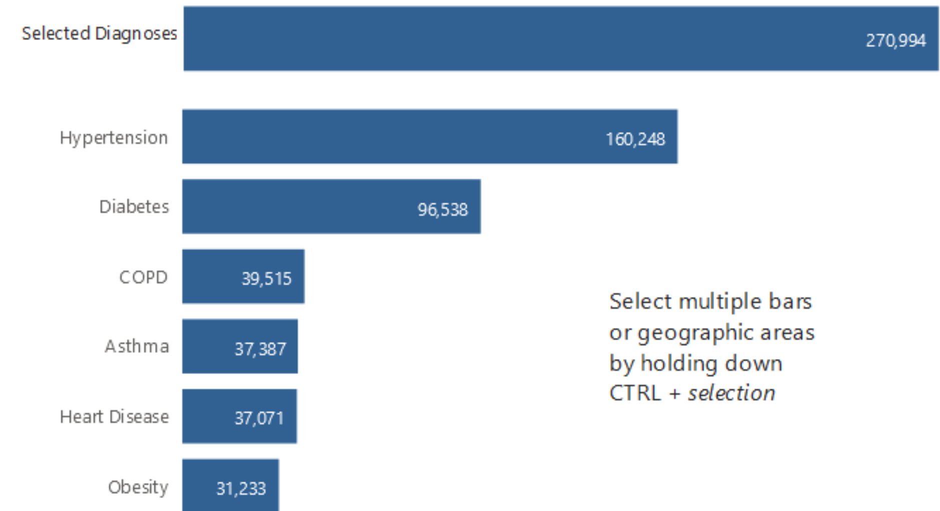
Age: All

Insurance Type: All

Gender: All

Condition	Count
Asthma	37,387
COPD	39,515
Diabetes	96,538
Heart Disease	37,071
Hypertension	160,248
Obesity	31,233





This report shows a total count or per capita rate of Rhode Island residents who have at least one of six chronic conditions known to increase the risk of morbidity or mortality if infected with COVID-19. Click the top bar to filter the report by age, insurance type, and gender. For more information about how this report works, please visit the Report Navigation page.

Data points with fewer than 11 members are suppressed. Source: HealthFacts RI, the Rhode Island all payer claims database. Back to Report List

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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
- Quality of care
- 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 Onpoint, the APCD platform vendor

Chronic Conditions

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

Chronic Condition

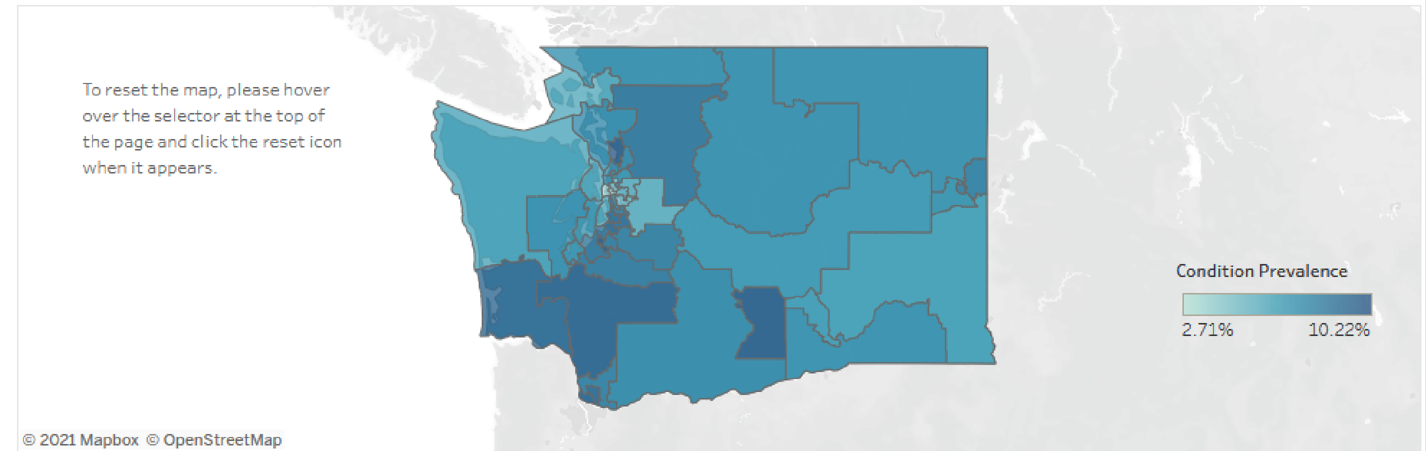
Diabetes

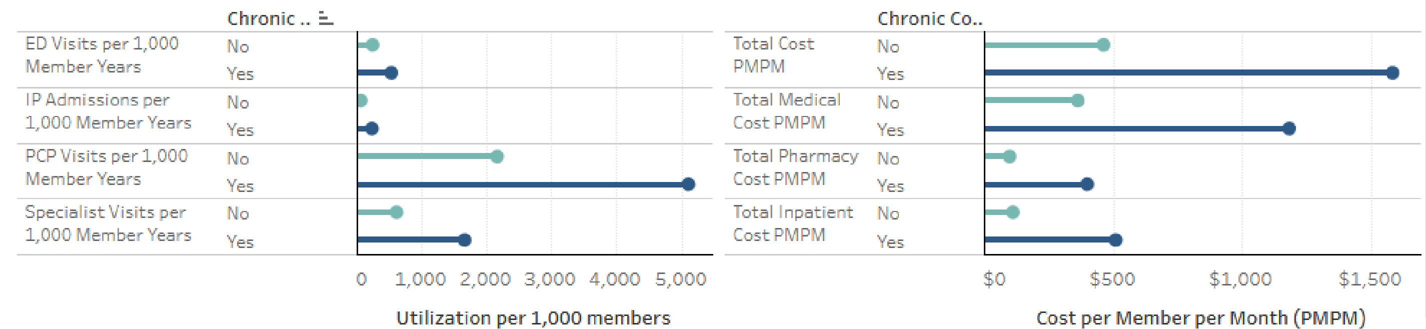
ADHD
Asthma
Breast Cancer
Congestive Heart Failure
COPD
Depression
Diabetes
Heart Disease
Hypertension
Stroke

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

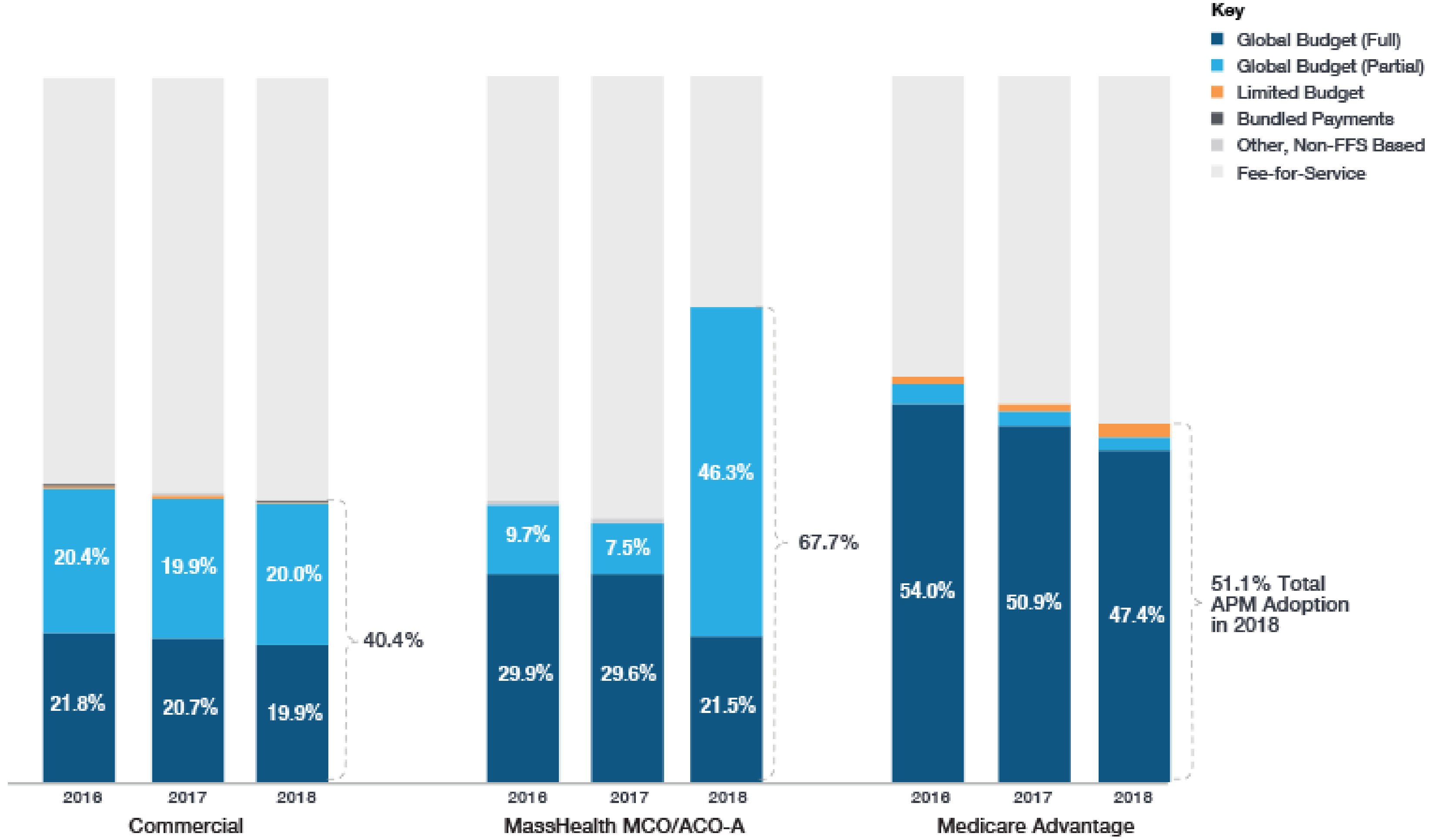
Longer-Term

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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Tier 1 ("Sooner"): Tentative Topics

- Initial Utilization Statistics
- Initial Cost Reporting
- Chronic Condition Prevalence
- Component Utilization and Cost (e.g., ED, Inpatient)
- Trends in Utilization
- COVID-19 Utilization, Cost

Initial public reporting will focus on summary statistics and analysis that can be supported by early data.

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Tier 2 ("Next") Priorities

Cost and utilization Statistics

Low Value Care

Costs for Episodes of Care

Health Disparities

Chronic Conditions

Prescription Drug Spending

Primary Care Spending

Behavioral Health Utilization

What input do you have on how HCAI sequences second-tier reporting topics?

- What should be pursued first, and why?
- What is missing?

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