



NATIONAL ASSOCIATION OF HEALTH DATA ORGANIZATIONS

Improving Health Care Data Collection and Use Since 1986

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Centers for Medicare & Medicaid Services: Innovation Center New Direction Request for Information Comments

**Submitted by the All-Payer Claims Databases (APCD) Council, a joint collaboration between the
National Association of Health Data Organizations (NAHDO) and the University of New Hampshire's
Institute for Health Policy and Practice**

November 20, 2017

These comments are being submitted on behalf of the membership of the National Association of Health Data Organizations (NAHDO) and the All-Payer Claims Database (APCD) Council Learning Network of states. NAHDO/APCD Council has been working for decades with states to establish statewide health care reporting systems and to standardize the content and the reporting of these data sources. Hospital reporting systems contain inpatient and Emergency Department data on all payer and all patients from all acute care hospitals in a state and is an essential source of population-based morbidity and outcomes data in states. APCD reporting systems include data from private and public (Medicare and Medicaid) payers in a state and include medical, pharmacy, dental, claims and enrollment data. Though there are exceptions, these data systems typically are legislatively-mandated reporting initiatives and are intended for public use and public reporting purposes. In some states, the State Innovation Model (SIM) programs have provided funding for planning or enhancing APCD reporting in states to support delivery system transformation.

As a national health care data association, we are primarily focused on supporting efforts related to ensuring that there is reliable, consistent data available to inform, support, and evaluate efforts related to transformation of health care into a more affordable, accessible system. Thus, our comments in this response will be focused on the importance of comprehensive data to inform, implement, and evaluate any and all of the proposed models. Other organizations will be better positioned to suggest models for delivery of care and payment reforms. Regardless of care model, innovation requires information as well as consistency in data, methods, and tools across the system.

1. Comments on guiding principles or focus areas

We agree with CMS' emphasis in this RFI on the need for information, transparency, and data-driven approaches and the need in any model for robust tools for the demonstration of outcomes in evaluating the efficacy of models that are implemented. All of the Innovations Center's guiding principles are data-intensive in order to provide consumers, providers, and payers with information needed to inform decisions, foster accountability, promote competition, monitor trends and patterns of care, and improve delivery system performance and population health.

Providers entering into any payment model will be faced with reporting requirements and needs for data to inform their work. Statewide data could be a supplemental or additive source of system-wide data that provides information beyond a single-entity reporting solution which provides only partial view of care and cost patterns (see the HCP LAN report, which described in detail the need for data infrastructure: <https://hcp-lan.org/workproducts/apm-whitepaper.pdf>). Data sharing and collaboration across sectors and between state and federal agencies will be important in order to achieve shared goals



and shared solutions for information needed to “foster an affordable, accessible health care system that puts patient first”.

States with APCDs have a long history of working to contain health care costs and improve health system performance using comprehensive, local, encounter-specific data. These states are documenting wide variations in costs and outcomes and targeting opportunities for interventions to reduce this variation. The Innovation Center should partner with states to improve, expand, and enhance existing data systems to provide population and system-wide information that can be used to evaluate new and existing payment models. The examples below illustrate the ways APCD data are being used to promote oversight and transparency of health care costs, quality, and utilization.

- **Assessing geographic variations in price and utilization.** The Oregon Health Authority publishes quarterly reports that compare per-member per-month costs and utilization, by service category, for commercially insured, public employees, and public payers (<http://www.oregon.gov/oha/hpa/analytics/pages/index.aspx>). Colorado uses its APCD to study price variation for common procedures among facilities (<http://www.civhc.org/get-data/interactive-data/statewide-metrics/cost-of-care/>). Maryland uses APCD data to compare the unit-costs, utilization, per-member per-month costs, out-of-pocket and insurance payments, geographic variations, and physician access data across geographic regions (<http://mhcc.maryland.gov/transparency/Default.html>).
- **Promoting cost and quality transparency and protecting consumers.** Both New Hampshire’s HealthCost (<https://nhhealthcost.nh.gov/>) and Maine’s CompareMaine (<http://www.comparemaine.org/>) websites provide provider-specific price and quality information to consumers, health plan enrollees, and employers to promote health care comparison shopping through cost- and quality-transparency tools. Both systems have historically included data from self-funded health plans to make these consumer tools available to enrollees of self-funded employee health plans.
- **Tracking health care spending drivers and trends.** Massachusetts used its APCD data to produce an annual report analyzing trends in health care spending for commercial payers by category of service, type of episode, and geographic area (<http://www.mass.gov/anf/docs/hpc/apcd-almanac-chartbook.pdf>). Minnesota used its APCD data to analyze prescription drug spending by therapeutic category and setting (office-administered vs. pharmacy benefit) (http://www.health.state.mn.us/healthreform/allpayer/20160229_rxtrends.pdf). Rhode Island released a report analyzing the top 15 clinical complaints and associated costs of potentially avoidable emergency room visits broken down by payer type (<http://health.ri.gov/data/potentiallypreventableemergencyroomvisits/>).
- **Promoting public health.** Organizations in Virginia (<http://www.vhha.com/research/2016/01/29/data-show-southwest-virginia-hard-hit-by-opioid-crisis/>) and Utah (<http://healthinsight.org/files/Utah%20Partnership%20for%20Value-Driven%20Healthcare/Transparency%20Advisory%20Group/In-Person%20Events/TAG%20Slides%204-19-16%20final.pdf>) have used APCD data to track opioid prescription claims across geographic areas and patient characteristics to understand and address trends in opioid use as have the Agency for Healthcare Research and Quality (https://www.hcup-us.ahrq.gov/datainnovations/Opioid_trends_ICD_Med_Care.pdf). New Hampshire used APCD data to measure access to and utilization of preventive services, such as

cancer screening or diabetic testing and treatment, among its adult Medicaid population (<https://www.dhhs.nh.gov/ombp/documents/adultpreventivebrief.pdf>)

- States are using their data systems to improve outcomes and reduce costs associated with avoidable inpatient and Emergency Department visits and hospital readmissions (https://profiles.health.ny.gov/measures/all_state/16284)

These examples are in alignment with the guiding principles articulated in this RFI, and can be the basis for tools to provide information for the development, implementation, and evaluation of the new modes. Many more examples can be found at www.apcdshowcase.org. More specifically, potential ways state-based hospital discharge and APCD data systems could support the CMS models identified in the RFI include:

Advanced APMs: All forms of Alternate Payment Models (APMs) will likely include reporting requirements that capture the appropriate data to support the shift of the payment from fee-for-service to being value-based. Demonstrating value will require data that are comparable across sites of care and time. As APMs are created, data collection needs should be considered and mechanisms to collect data should be a key planning effort. This includes the development of ways to collect financial arrangements outside of encounter-based reporting, while not losing encounter level information. It is critical that detailed data reporting be maintained. Mistakes from Managed Care models in the 1990s, when encounter-level data were “lost” in plans that were capitated, should not be repeated.

Consumer-directed models: Information essential to support transparency for patients is essential. We agree with the CMS’ promotion of the development of models to “facilitate and encourage price and quality transparency, including the compilation, analysis, and release of cost data and quality metrics that inform beneficiaries about their choices.” State data systems, in the examples provided above, and in many other ways, currently support efforts to provide better, more transparent information to consumers and other stakeholders. With additional investment, these efforts can be greatly expanded and directly support this goal of CMS to provide consumers better information to support decision-making. When the public and policy makers are able to access price information on common conditions, they are surprised by the large price variation—which is a key step to consumer engagement and improvement initiatives. As consumers assume more of their health care costs through higher deductibles and co-pays, pricing information is essential, but not widely available. New models for state-federal data sharing and exchange, as well as model website tools and templates, could streamline these efforts.

Specialty Physician Models: State data systems exist that can provide information to support any number of model designs. This includes using state-wide APCD data to develop regional healthcare utilization pattern reports, specialty attribution models, and episode of care analysis. Additional investment in analytic tools that are open-source and/or non-proprietary methods that can be used consistently will provide more consistent information to support physician models.

Prescription Drug Model: States with statewide pharmacy claims and medical claims files can support broad views of trends and utilization patterns, information about cost variation and pricing, and tools for benchmarking. This type of baseline and evaluation data will be key in effective development and implementation of models to address prescription drug efficacy and costs.

Medicare-Advantage Models: Statewide hospital discharge data bases capture all payers including Medicare Advantage. State APCDs can capture administrative data on Medicare Advantage populations and these data sources can be useful to CMS as it plans to provide “regulatory flexibility” to plans. State data sets can also be incredibly useful for comparative analysis and benchmarking of these plans to other commercial and public plans, in terms of cost and utilization. Such flexibility is best when balanced with accountability and transparency, which these data could provide. CMS needs to add clarity to their Medicare Advantage contract to confirm plan reporting to the state APCD.

State-based local innovation: We agree whole-heartedly with CMS’ emphasis of driving change at the state-level and believe that the desire to “partner with states to drive better outcomes for people based on local needs” should be part of the new direction for the Innovation Center. States with APCD reporting have an advantage by having a comprehensive source of information to target and drive improvements, measure, and evaluate effectiveness at the local level. Cost and utilization reports described in the examples above (e.g., Oregon) support the statewide transformation efforts, using statewide APCD data. As states work with CMS “to develop state-based plans and local innovation initiatives to test new models”, state-based data systems will be a crucial tool for informing, implementing, and evaluating those models.

Mental Health/Behavioral Health Models: As with any other model, the development of effective models in Mental Health/Behavioral Health need to be informed by reliable, statewide and system-wide data. State data systems have been used to develop BH-specific provider attribution models and describe the differences in cost and utilization for people with MH/BH conditions. There are challenges in describing care related to MH/BH issues, included carved out benefit plans and restrictions related to 42CFR Part 2 that will be important for CMS to address in order to have the robust data it needs to effectively develop models.

Program Integrity: Robust data systems, which contain data across payers and systems of care, can be effective in developing tools to reduce fraud, waste, and abuse.

In summary, all of the models described in this RFI will rely on the preservation and further advancement of patient-level/encounter-level data reporting for reasons of accountability and population health management. Extending payment innovations to all payers will enhance both the APMs and the delivery system performance as a whole, and infrastructure investment in data partners at the state-level will allow CMS to leverage the existing resources available, as well as advance those resources to meet new needs related to the new direction of the Innovation Center.

2. Structure, approach, and design of potential models

Although stated above, we emphasize the recommendation that all proposed models require sustainable and ongoing sources of comparable system-wide data. Data from one individual payer, for one system or geographic area, does not provide sufficient data and information to inform the robust model development and implementation contemplated by CMS. For purposes of reducing reporting burden and increasing the scope of measurement, models that partner with state agencies to share and exchange data should be encouraged. Additionally, leveraging existing data systems in states is preferable to creating a parallel reporting infrastructure at the federal level which will be costly.

The NAHDO/APCD Council make the following recommendations for state-federal collaboration to improve data to support making a more affordable, accessible health care delivery system:

1. Support continued development and standardization of claims-based data: States and payers collaborated to develop content standards for APCDs, known as the Common Data Layout (CDL (<https://www.apcdouncil.org/standards>)). Federal assistance is needed to maintain and update and implement these standard reporting formats, which will reduce payer reporting burden and improve comparability of claims-based data across states.
2. Consider shared solutions to common technical issues, where possible. We invite CMS and the Innovation Center’s continued collaboration with states and NAHDO/APCD Council to solve difficult technical issues related to claims-based data collection and transparency reporting. Seeking common solutions to improving cross-cutting issues will benefit all. This includes:
 - a. Physician identifiers and attribution
 - b. Standards for data quality/claims data edit logic
 - c. Open-source measures and tools, such as episodes of care, consumer transparency tools, and quality measures
3. We invite federal-state collaboration to fill important data gaps:
 - Self-funded data from ERISA-covered employers
 - Substance Use Disorder (SUD) data regulated by 42 CFR Part 2 (https://www.apcdouncil.org/sites/apcdouncil.org/files/media/part2_apcd_council_comments_final.pdf)
 - Federal Employee Health Benefit Plan (FEHBP) administrative data

In closing, we welcome the opportunity to explore how to partner with the Innovation Center to leverage the learning network infrastructure and activities in place to advance our common interests in having reliable data to support the development, implementation, and evaluation of models proposed in this RFI. Innovation Center support of Learning Network activities can be mutually beneficial to healthcare providers, states, and CMS to develop and disseminate effective practices across private, state and federal health care information initiatives.

Sincerely,

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