Using An APCD to Inform Healthcare Policy, Strategy, and Consumer Choice

Maine’s Experience
What I’ll Cover Today

• Maine’s History of Using Health Care Data for Policy and System Change
• Health Data Agency and Governance Structures of APCD and Other Databases
• How APCD’s Have Helped Inform Policy and Health Care System Change
• How APCD’s Will Inform Policy and Health Care System Change in the Near Future
• APCD’s – Not a “Silver Bullet”, Structural Challenges, Political and Legal Challenges
• National and Regional Resources
Maine’s All-Payer Claims Database

– First in Nation – 2003
– Commercial, Medicaid, and Medicare data
– Doesn’t include TriCare, V.A., or Indian Health Services
– No uninsured
We Started With a Question: “Why is Healthcare So Costly in Maine?”

• For this type of question we really need a whole view of healthcare consumption, APCD’s are able to provide most of that view.
Unwarranted variation, as defined by the Dartmouth Atlas is inappropriate delivery of services due to under-use, overuse and/or misuse of care and can be categorized into three domains:

• **Effective Care and Patient Safety**: Services of proven clinical effectiveness derived from randomized controlled trials, or well-constructed observational studies. These are the traditionally defined ‘quality’ measures.

• **Supply-Sensitive Care**: Care that is strongly correlated with healthcare system resource capacity and is an indicator of the efficiency of the healthcare system (i.e. admissions rather than outpatient treatment for patients with chronic conditions such as diabetes or chronic obstructive pulmonary disease).

• **Preference-Sensitive Care (PSC)**: Care for which the treatment options carry significant tradeoffs in terms of risks and benefits for the patient and there is limited clinical evidence favoring one option over another.
Analyzing the APCD Produced Important Insights Into Healthcare Delivery and Consumption

Key findings from the analysis include:

Total cost is a function of volume of services (utilization) and price per service. Of these two variables, we found utilization, or service volume, to be the more powerful determinant of cost.

Significant variation in per-capita spending exists across Health Service Areas (HSAs) for both inpatient and outpatient care.

A significant portion of inpatient care (>30%) is “potentially avoidable” (PA). Potentially avoidable does not mean preventable or that 30% of inpatient spending can be eliminated; rather, that through analysis and interventions, it can be reduced. See full report for further definition.
APCD Allows Comparisons Across Payers

Table 3: Per Member per Year Costs by Payer by Service Category

<table>
<thead>
<tr>
<th>Service Category</th>
<th>Commercial</th>
<th>Medicare</th>
<th>Medicaid</th>
<th>Dual</th>
</tr>
</thead>
<tbody>
<tr>
<td>IP PMPY</td>
<td>$822</td>
<td>$2,144</td>
<td>$1,072</td>
<td>$3,356</td>
</tr>
<tr>
<td>ER PMPY</td>
<td>$149</td>
<td>$81</td>
<td>$230</td>
<td>$207</td>
</tr>
<tr>
<td>OP PMPY</td>
<td>$1,780</td>
<td>$1,682</td>
<td>$1,535</td>
<td>$3,292</td>
</tr>
<tr>
<td>Total Paid PMPY</td>
<td>$2,752</td>
<td>$3,907</td>
<td>$2,837</td>
<td>$6,855</td>
</tr>
</tbody>
</table>

As expected, those members with dual coverage have higher costs PMPY as compared to all other payers. Those members with straight Medicare coverage also have higher cost per member, presumably because they are an older population. Interestingly, the MaineCare and Commercial populations have similar PMPY; however, the MaineCare population shows a higher proportion of spend in the inpatient and emergency room categories, whereas the Commercial population is higher in the Outpatient categories. (Note: MaineCare costs have not yet been reconciled for this time period).
Example: Variation in Potentially Avoidable Inpatient Use

PA does not mean hospitals did anything inappropriate in admitting the patient. Rather, it means that for a range of reasons, the entire local health care delivery system is not providing the right care at the right place at the right time to treat a person efficiently & effectively.

*Adjusted for age, sex, and illness
Information Informed Legislature

Report to the Legislature
from the
Advisory Council on Health Systems Development

Health Care Cost Drivers in Maine

Report and Recommendations

April 2009
### Average Statewide Procedure Payments and Charges

Please select the year of data you would like the report below to display. It contains statewide charge and payment information across all insurance carriers and all medical providers. Included are amounts for the professional (provider) portion and for the facility (e.g. hospital) portion of a procedure.

Each procedure has a histogram you may view by clicking the "View Histogram" link under the procedure title.

Please see "Notes" at the bottom of the report for additional information.

**Select Year of Report:** 2010

<table>
<thead>
<tr>
<th>Procedure Description</th>
<th>CPT4 Procedure Code</th>
<th>Average Professional Charges</th>
<th>Average Professional Payments</th>
<th>Average Facility Charges</th>
<th>Average Facility Payments</th>
<th>Average Total Charges</th>
<th>Average Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arthroscopic Knee Surgery (Outpatient) View Histogram</td>
<td>29881</td>
<td>$3,376</td>
<td>$1,617</td>
<td>$5,458</td>
<td>$4,765</td>
<td>$8,834</td>
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</tr>
<tr>
<td>Biopsy - Breast (Auto Vacuum) View Histogram</td>
<td>12103</td>
<td>$1,776</td>
<td>$723</td>
<td>$3,356</td>
<td>$2,886</td>
<td>$5,132</td>
<td></td>
</tr>
<tr>
<td>Bronchoscopy View Histogram</td>
<td>31022</td>
<td>$5,243</td>
<td>$2,209</td>
<td>$10,328</td>
<td>$7,761</td>
<td>$15,571</td>
<td></td>
</tr>
<tr>
<td>Carpal Tunnel Release View Histogram</td>
<td>64721</td>
<td>$2,185</td>
<td>$1,004</td>
<td>$3,538</td>
<td>$2,918</td>
<td>$5,723</td>
<td></td>
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<tr>
<td>Colonoscopy View Histogram</td>
<td>45378</td>
<td>$372</td>
<td>$371</td>
<td>$1,631</td>
<td>$1,331</td>
<td>$2,503</td>
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</tr>
<tr>
<td>Colonoscopy With Biopsy View Histogram</td>
<td>57454</td>
<td>$749</td>
<td>$416</td>
<td>$331</td>
<td>$321</td>
<td>$1,080</td>
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</tr>
<tr>
<td>CT - Abdomen View Histogram</td>
<td>74160</td>
<td>$318</td>
<td>$105</td>
<td>$1,391</td>
<td>$1,034</td>
<td>$1,709</td>
<td></td>
</tr>
</tbody>
</table>
Data Requests for APCD Data are Growing

<table>
<thead>
<tr>
<th>Request Number</th>
<th>Affiliation</th>
<th>Requesting Party</th>
<th>Date Posted</th>
<th>Comment Close Date</th>
<th>Specific Data Request</th>
<th>Purpose of Request</th>
</tr>
</thead>
<tbody>
<tr>
<td>926126</td>
<td></td>
<td></td>
<td>09-06-2012</td>
<td>09-18-2012</td>
<td>2012 - 2014 Restricted Medical Claims, Pharmacy Claims and Member Eligibility Data, with Practitioner Identifiers</td>
<td>The data will be used to inform our health system's efforts to (1) improve the quality and safety of the services provided, (2) identify opportunities to make the services provided less costly, and (3) support member organizations and strategic affiliates to assume the responsibilities and risks of an Accountable Care Organizations participating in the Medicare Shared Savings Program and similar arrangements with commercial payers and the MaineCare Program's planned managed care initiatives. The data will be used in evaluating the</td>
</tr>
</tbody>
</table>
Data Needs to Support Health Reform

• Health systems, ACOs will need new mechanisms to continually gather, assess and act on real-time data to measure provider performance, quality, outcomes
• Purchasers and payors need timely data to formulate new payment methodologies
• Consumers need data on provider performance, outcomes, and costs
• Policymakers need comprehensive data on disease incidence, treatment costs, health outcomes
ACO Framework

Stakeholders/key leverage points

1. Payers: Coordinate pilots across payers, develop benefit plans that incent patient involvement, quality and efficiency

2. Develop payment models to be implemented over time/with interim steps that incent quality and efficiency (payments to systems/aggregators & payments to providers)

3. Providers/Delivery Systems: Restructure healthcare delivery to create high quality and efficient systems (capacity, resource allocation, infrastructure, care coordination…)

4. Population: Approach consumers, beneficiaries, individuals, employees from a population-based longitudinal perspective, address needs/create programs along the continuum
Implications for Measurement: to improve health care value we need patient-focused feed forward information

- Need to measure changes in health status, quality & costs using feed forward and feedback principles
- Need to include patient-reported data to measure health outcomes and value
- Need to design and implement new HIT systems to accomplish this -- good news technology is (almost) ready
- Demonstrations have shown the utility and feasibility of this approach
Practical Applications for Public Data: Current Uses and Challenges

**Current**

- Geographic / organizational variation analysis
- ACO attribution modeling and network development
- Network and hospital service area leakage analysis

**Future**

- All of the above, plus ACO Quality and Efficiency Management

**Challenges**

- Data complexity: Limited in-house capacity for management & analysis
- Consistency:
  - Changes in MHDO submission requirements and require complicated “cross-walking” that may compromise year over year trending
  - Reporting of pharmacy and behavioral health claims inconsistent across payers – compromises comparison
- Timely Availability
To Measure Health Status & Outcomes …

Need **Patient** Reported Data

- Physical
- Mental
- Social/Role
- Behaviors

**Function & Risk**

**Disease**
- Mortality
- Morbidity
- Symptoms

**Costs**
- Direct Medical
- Indirect Social

**Experience**
- Health Care Delivery
- Perceived Health Benefit
Recommendations For Timely and More Comprehensive Data

Providing Better Care at Lower Cost: Building Maine’s Health Data Infrastructure to Support Financing and Delivery System Reform

Report of the Health Data Workgroup to Advisory Council on Health Systems Development

Office of the State Coordinator for Health Information Technology
Maine Center for Disease Control and Prevention
Maine Department of Health and Human Services

March 2011
HealthCare Data Workgroup Recommendations

1. **Recommendation #1**: Design a Strategy for Linking and Storing Clinical and Administrative Data

2. **Recommendation #2**: Develop Provider, Practice and Patient Identification and Data Linkage Strategies to Support Quality Improvement and Cost Management Uses of Health Data

3. **Recommendation #3**: Define Core Health Status and Population Health Data and Measures
HealthCare Data Workgroup

Recommendations

Recommendation #4: Develop a Strategy for Building Maine’s Capacity to Use Data to Inform Quality Improvement and Cost Management

Recommendation #5: Produce Regular Report(s) on the Performance of Maine’s Health System
LD 1818 - Resolve To Evaluate the All-Payer Claims Database System for the State

Stakeholder Work Group

Next Meeting:
Date: August 16, 2012
Time: 9:00am-12:00pm
Location: Room 600 Cross Office Building - Augusta

Handouts:
- Agenda 8-16-12-LD 1818 (.doc)
- LWG Presentation 8_16 (.doc)
- LWG PHI Pyramid (.pdf)
- LWG PHI Pyramid (.ppt)
- LWG Detail Grid (.xlsx)
- LWG Detail Grid (.xls)
- LD1818 Meeting Summary 8-9-12 (.doc)
- LD 1818 VOC Themes Document (.pdf)
- LWG Definitions (.doc)
- VOC Sub Committees (.doc)

Communication:
- Admin support email 7-31-12 LD 1818 (.doc)
Legal Work Group
PHI Pyramid
General PHI (non-sensitive)

Informed Consent
  Disclosure Allowed
  Treatment Payment Operations
    Allowed for TPO

Public Health
  Allowed when required by law

Fund Raising
  Allowed for entity

Research
  Restricted

Marketing
  Consent required
PHI Mental Health

Disclosure Allowed

Allowed for payment; T+O are restricted + vary for agency vs. clinician

Restricted; can disclose to DHHS in limited circumstances

Consent required

Restricted; limited exceptions

Consent required
PHI Federal Substance Abuse Program

Disclosure Allowed
Only with patient consent
No exception listed; LWG opinion patient consent required
No exception listed; LWG opinion patient consent required
Restricted
Consent required
PHI HIV

Disclosure Allowed

Allowed for direct treatment

Allowed when required by law

Statute is silent; LWG opinion use requires consent

Restricted; researchers can’t re-disclose

Consent required
National Resources for APCD Information

Contact Information
patrick.miller@unh.edu
603.536.4265

www.apcdcouncil.org
Questions?

Thank you!