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Arkansas Healthcare Transparency Initiative

April 12, 2016

ARKANSAS APCD All-Payer Claims Database

ADMINISTERED BY ACHI Arkansas Center for Health Improvement

Agenda

- Approval of minutes
- Environmental scan
- Dashboard prototype
- Sustainability plan
- Supreme Court ruling
- Data submission status update
- Data request process/forms
- Initiative website
- Other business

Environmental Scan

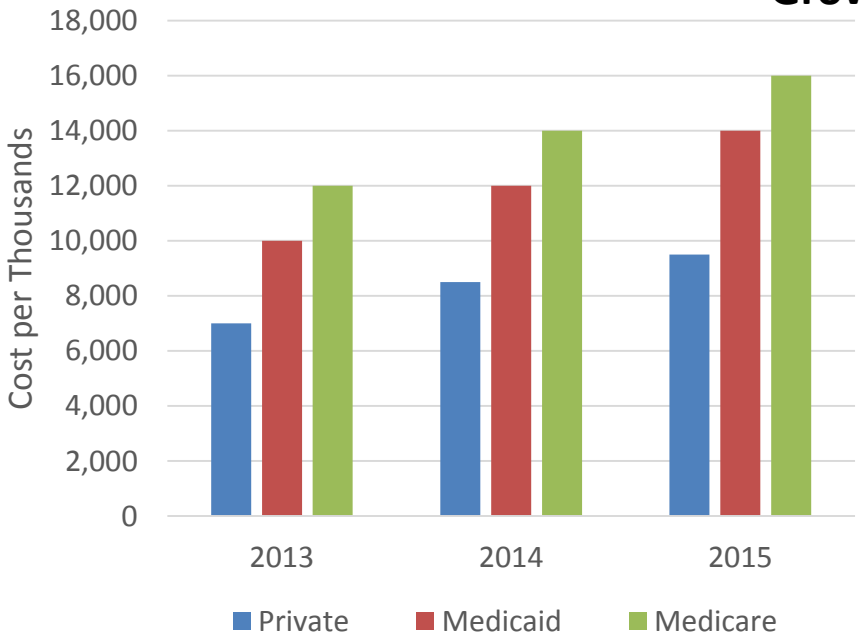
- Task Force consultants have consistently recommended dashboard of metrics for monitoring and compliance
- Proponents of both Medicaid reform bills express desire for Medicaid dashboard of measures
- DiamondCare has a focus on value-based purchasing with bonuses for performance in quality, patient experience, resource use and cost
- DiamondCare bill sets forth dashboard specifics
  - Enrollment by eligibility group
  - Paid claims by eligibility group
  - Medicaid provider performance measures
  - Budget trends for healthcare services spending
  - Population health data, including diabetes, prescription adherence, and obesity
- Bill calls for a plan to implement dashboard before January 2017

Arkansas All Payer Claims Database

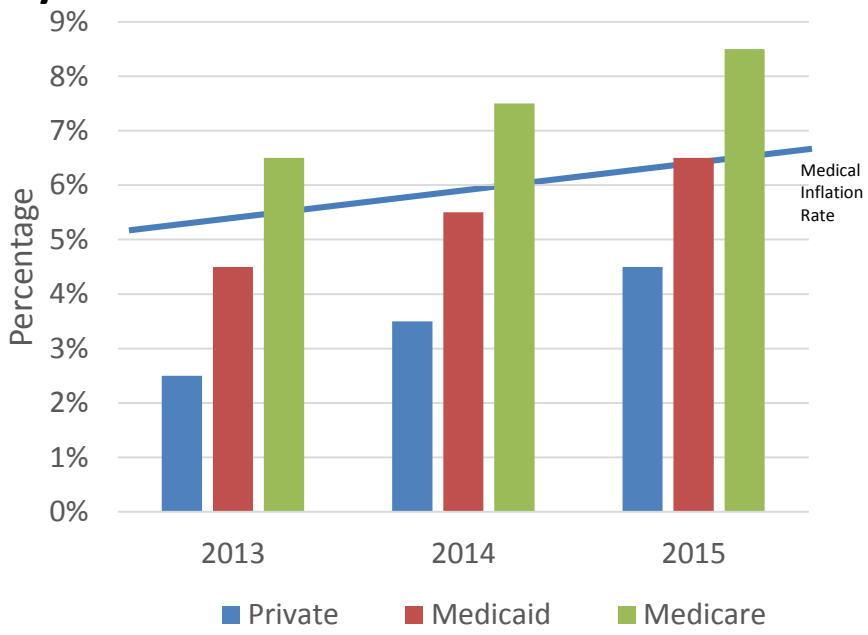
Administered by ACHI
With support from the Arkansas Insurance Department Health Insurance Rate Review Division

Dashboard Prototype

Annual Per Member Per Year (PMPY) Cost by Payer and PMPY Cost Growth by Payer



Annual average cost per member per year 2013-2015 by payer



Annual average cost growth per member per year 2013 through 2015 by payer

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Dashboard Prototype

Display Results

Select Payer: Medicaid

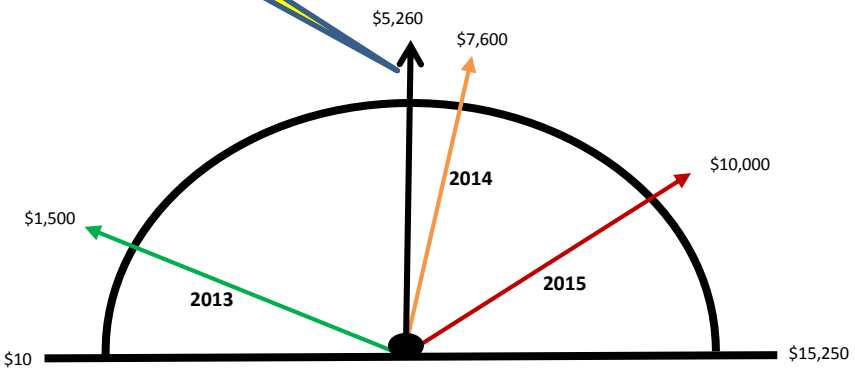
Select Population Group/Type: ACA Eligible

Submit

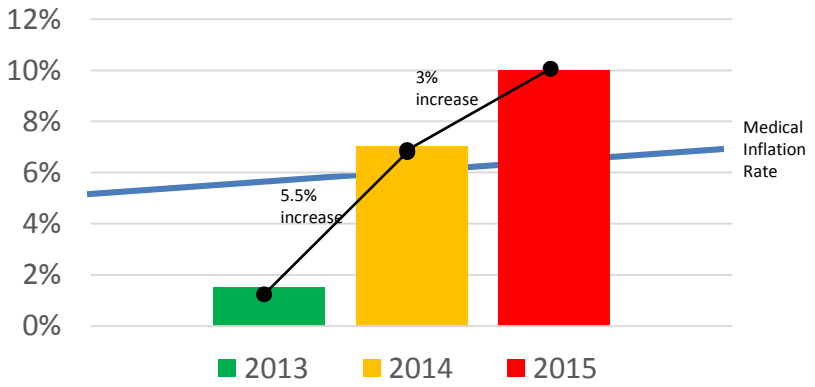
Cost Indicators for [Payer] by Selected Population: [population group]

Average cost for category for 3 years

Text box containing description of Population Group/type. Would change based on population group selected.



Annual average cost per member per year (PMPY) compared to 2013-2015 average cost PMPY



Annual average cost growth per member per year 2013 through 2015

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Dashboard Prototype

Display Results

Select Payer: Medicaid

Select Population Group/Type: ACA Eligible

Submit

Should be carried over from previous screen

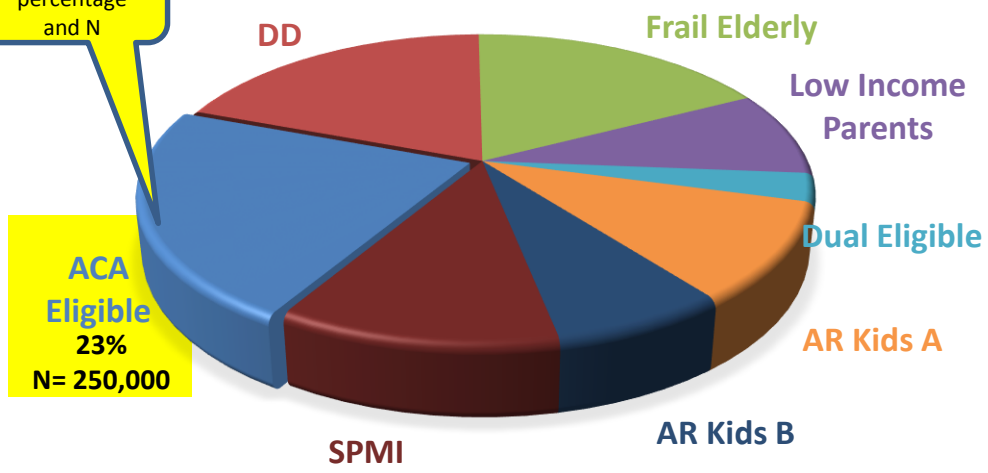
Should be carried over from previous screen

Cost Indicators for [2015] by Selected Population: [ACA]

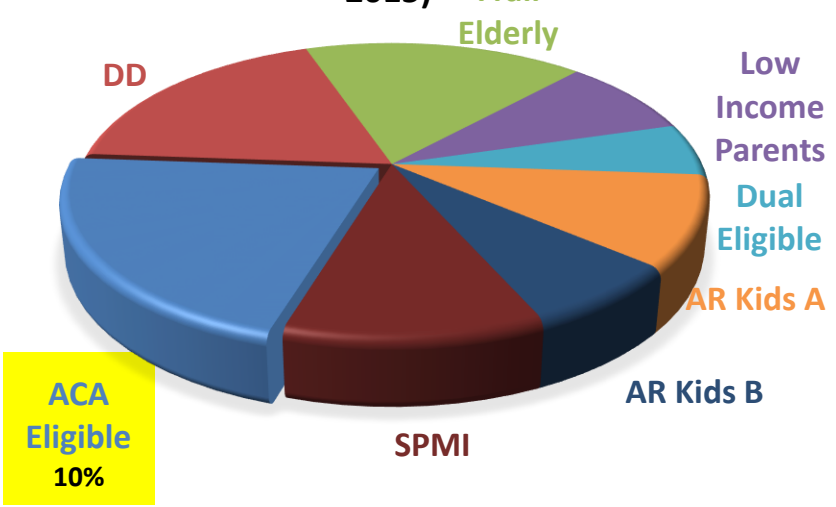
Text box containing description of Population Group/type. Would change based on population group selected.

Roll over section to see percentage and N

[ACA Eligible] Percentage of Total Beneficiaries



[ACA Eligible] Percentage of Total Programmatic Expenditures (2013-2015)



Description of what this means

Roll over to reveal methodology

BY ACHI

Arkansas All Payer Claims Database

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Dashboard Prototype

Display Results

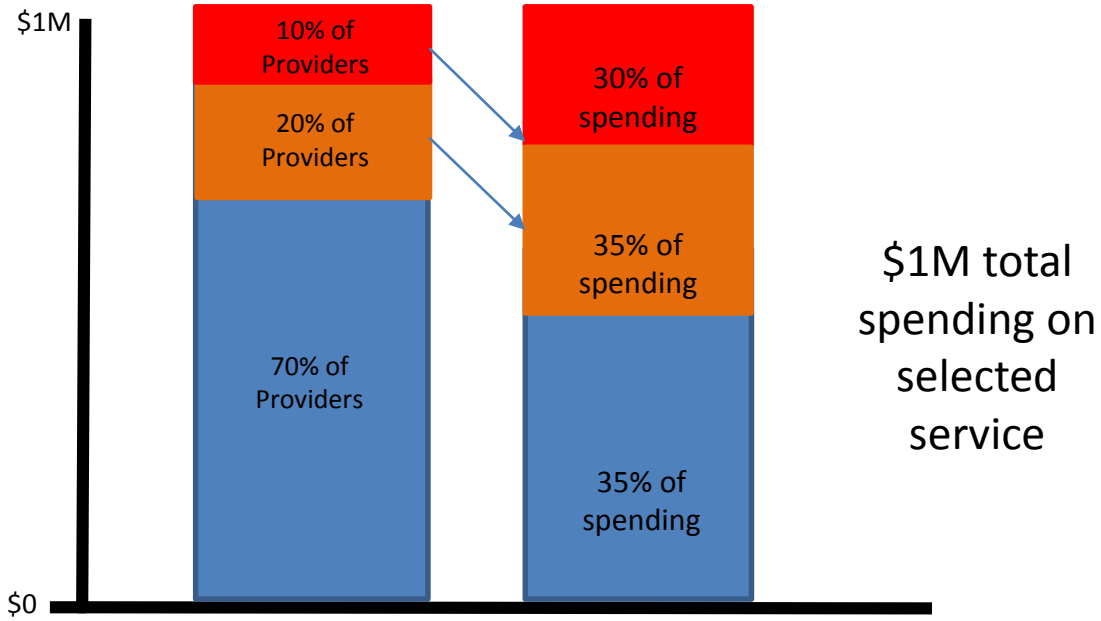
Select Payer: Medicare

Select Medical Service: Imaging: Low Back Pain

Submit

Payer Spending on Wasteful Imaging for Low Back Pain within the First Six Weeks [2015]

Text box containing description of graph below.



$1M total spending on selected service

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Gobeille v. Liberty Mutual Insurance Company

- Decided March 1, 2016
- Case involving the Employee Retirement Income Security Act of 1974 (ERISA) and all-payer claims databases (APCDs)
- The question before the Court was whether a state law requiring companies to submit medical claims data to the state was preempted by ERISA
- ERISA includes a provision that allows for broad preemption of state law, which aligns with the Supremacy Clause of the Constitution—when state law and federal law conflict, federal preempts state law
- Court ruled that ERISA preempts state law
- Rationale for the Court's ruling was to reduce the potential for "unnecessary, duplicative, and conflicting reporting requirements"

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Implication and Data Collection Alternatives

- In Arkansas 65% of private sector enrollees are in self-insured plans (2013)
- Significant amount of data shielded resulting in more limited understanding of healthcare costs and quality in the state
- National Academy for State Health Policy (NASHP) is convening a state work group with APCD Council to explore options
- Potential options
  - U.S. Department of Labor (DOL) issue regulations to collect data and share with state APCDs
  - DOL identify the key content, structural, and operational elements of approved APCDs and then certify those that meet standards while requiring states to transmit their data to a central warehouse
  - Seek voluntary data submission from self-funded plans

All-Payer Claims Database (APCD) Registration/Onboarding Status

- 19 groups are registered to submit data
- 11 entities have submitted test files
  - Technical team has processed over 500 individual test files and re-submisisons
- 17 exemptions have been requested to delay test file and historical file submission dates
- *No Group 1 entities were able to meet historical test file submission deadline
- Updated timeframe for historical files:
  - First anticipated Group 1 submission estimated for 4/22/2016

Data Release

Data Release Request Packet	Data Release Review Packet
Data Release Request Form	Data Request Process Overview
Data Management Plan	Project Evaluation
List of Requested Data Elements	Report and Results Review
Certification of Initiative Data Destruction or Retention	

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Data Release Request Form

What has changed?

- Removed the data product request section
- Clarified the data linkage section
- Added a qualifications and experience section
- Created a State Agency Data Release Request form and simplified process

Data Management Plan

- Similar to the Research Data Assistance Center that provides technical assistance to access data from the Center for Medicare and Medicaid Services
- Requires requestors to submit a plan that describes the physical, administrative, and technical safeguards in place to protect Initiative data

List of Requested Data Elements

- Provides instruction on how to use the form
- Allows the request of specific data elements
- Requires a justification for each data element

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Certification of Initiative Data Destruction or Retention

- Certifies that the project is complete and the data is destroyed or retained
- If data is retained, justification is required

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Standard Data Request Process

1. Initial Review by Administrator
2. Review by the Data Oversight Subcommittee*
3. Review by the Scientific Advisory Subcommittee, if necessary*
4. Review by the Initiative Board
5. Review by the AID Commissioner
6. Administrative Steps
7. Product Development and Delivery
8. Review of Results and Reports

*Bypassed for state agency requests

Evaluation Form

- Provides a guide for the data review process
- Describes basic criteria to consider when evaluating a request

Report and Results Review

- Provides a timeline for review and criteria to consider

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Phase I Measure Development

Measures to be included in the first phase of this initiative focus on readily-available data sources and known metrics.

Specifically, the first release of data will address the following areas:

1

Access

Access measures will provide a comparative view of the level of access offered by insurance carrier networks.

Specific measures include:

1. Provider Participation Rate;
2. Network Breadth Classification;
3. Provider-to-Enrollee Ratios; and
4. Average Distance to Providers.

2

Patient Experience

Patient experience measures will compare the performance of Arkansas hospitals on several patient experience metrics.

Specific measures include:

1. Patient Experience Score by Experience Category
2. Star Rating by Experience Category
3. Summary (Composite) Star Rating

Each of these measures is addressed individually within in this presentation.

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Access: Provider Participation Rate

Networks will be evaluated to identify the percentage of all providers within the State currently contracted within each specific issuer's network.

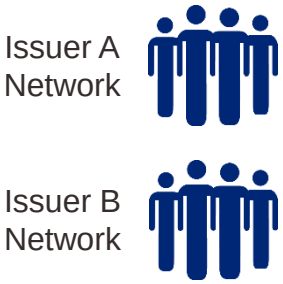
The percentage of all available providers at the issuer, network, county, and specialty combination level within an issuer's network will be that issuer's Provider Participation Rate (PPR).

The provider participation rate will be calculated within each county for:

(1) Primary Care Providers; **(2)** Pediatric Primary Care Providers; and **(3)** Hospitals.

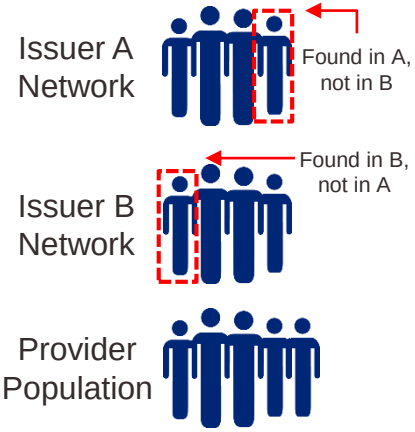
The Provider Participation Rate is calculated as follows:

1



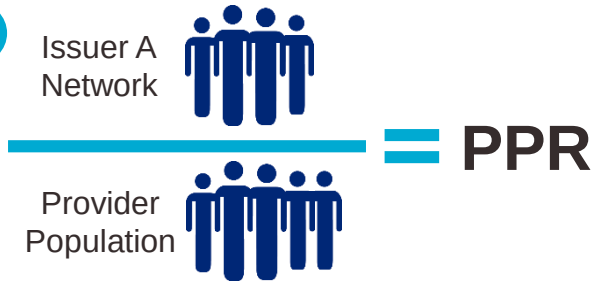
Issuer networks are loaded into a database; each individual provider is assigned a unique provider ID based on NPI and provider/facility location.

2



Unique providers are identified to produce the total provider population.

3



The proportion of all available providers found within that issuer's network is that issuer's Provider Participation Rate.

For example, a carrier contracted with **4 providers**, out of a **total population of 5 providers**, would have a **PPR of 80%**.

PPR Numerator = Carrier Provider Count

PPR Denominator = Total Provider Population

$$\text{PPR} = \frac{\text{Issuer Providers}}{\text{Available Providers}}$$

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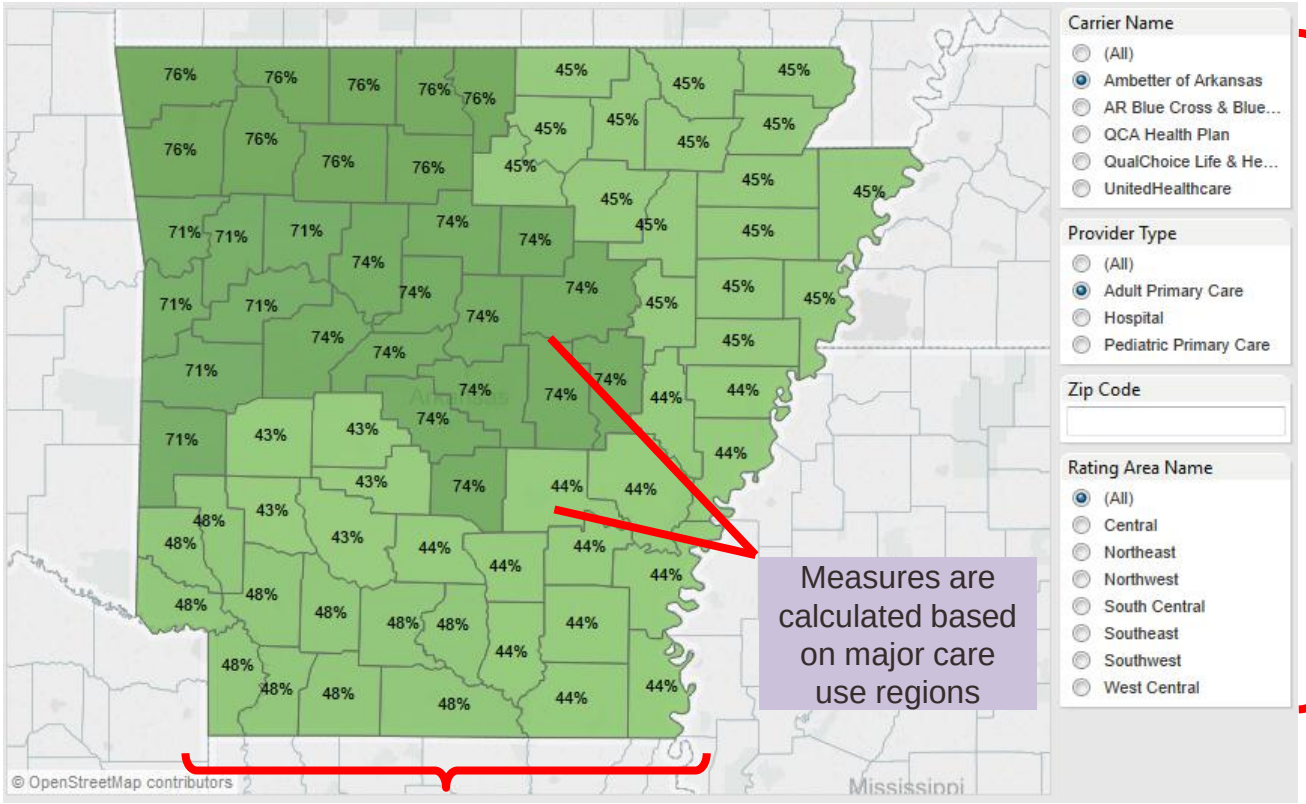
Concept: Provider Participation Rate

Measure outputs will be calculated for each of the 7 Arkansas centers of care, with multiple abilities to filter according to carrier, location, and provider type.



Filter options allow for data display based on:

- Carrier;
- Provider Type; and
- Location.

Localized data combines with a statewide view to allow users to easily benchmark the queried information

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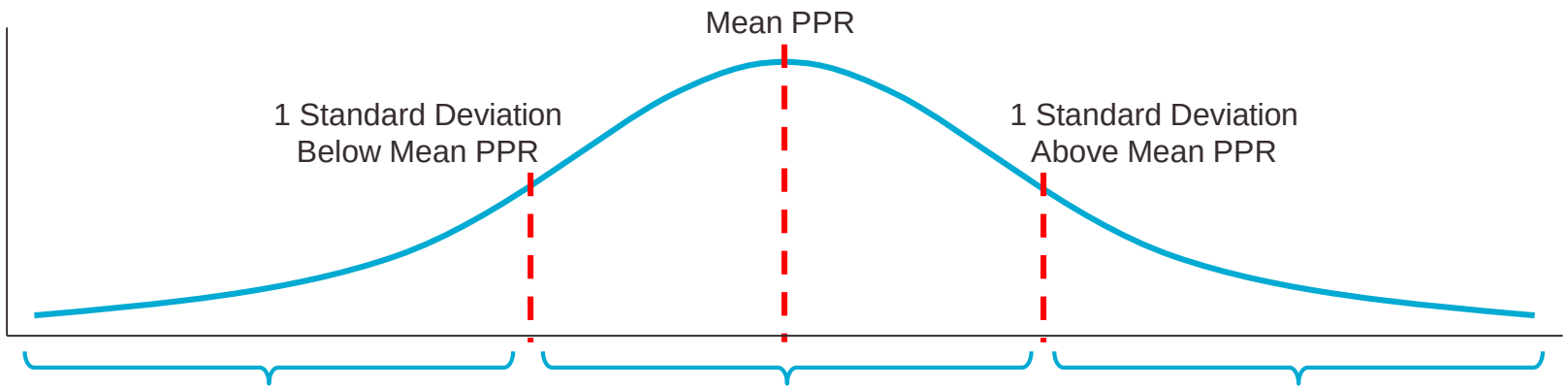
Access: Network Breadth Classification

Networks breadth classifications will be determined based on the Provider Participation Rate, following a classification methodology established by CMS.

Specifically, breadth classifications are assigned based on the variance from the mean (Z-Score) of all participation rates across carriers.

Similar to the PPR calculations, breadth classifications will be calculated within each county for:

(1) Primary Care Providers; **(2)** Pediatric Primary Care Providers; and **(3)** Hospitals.



Classification:
Narrow
Network is less inclusive compared to other carriers

Classification:
Standard
Network inclusion is similar to inclusion levels of other carriers

Classification:
Broad
Network is more inclusive than other carrier networks

Whereas the participation rate produces a raw score, the breadth classifications permit consumers to, at a glance, know the comparative breadth of provider inclusion offered through the network.

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Access: Average Distance to Provider

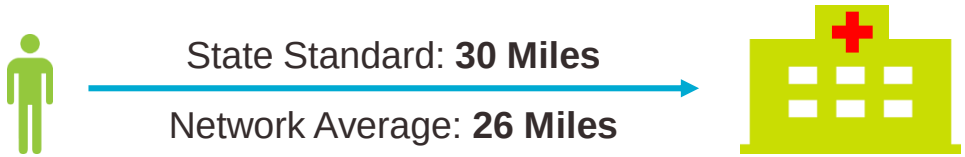
The average distance to an in-network provider describes geographic availability of providers for a carrier.

This measure is calculated using data reported by carriers to the Arkansas Insurance Department (AID) through the Specialty Access Template; no calculations are performed by AID to produce these measures.

Average-Distance measures are available for each of the 26 provider specialties for which AID measures access as part of the network adequacy review.

These measures calculate the average distance from an enrollee covered within a network to the nearest provider of a certain specialty classification. These averages are calculated for all enrollees and then aggregated to produce the distance measurement.

Example: Hospital Access



Average-Distance measures tie directly to state standards for network adequacy, as established in Arkansas Rule 106 – Network Adequacy.

The visualization tool for these standards can indicate both comparison across carriers and levels of compliance with Arkansas network adequacy requirements.

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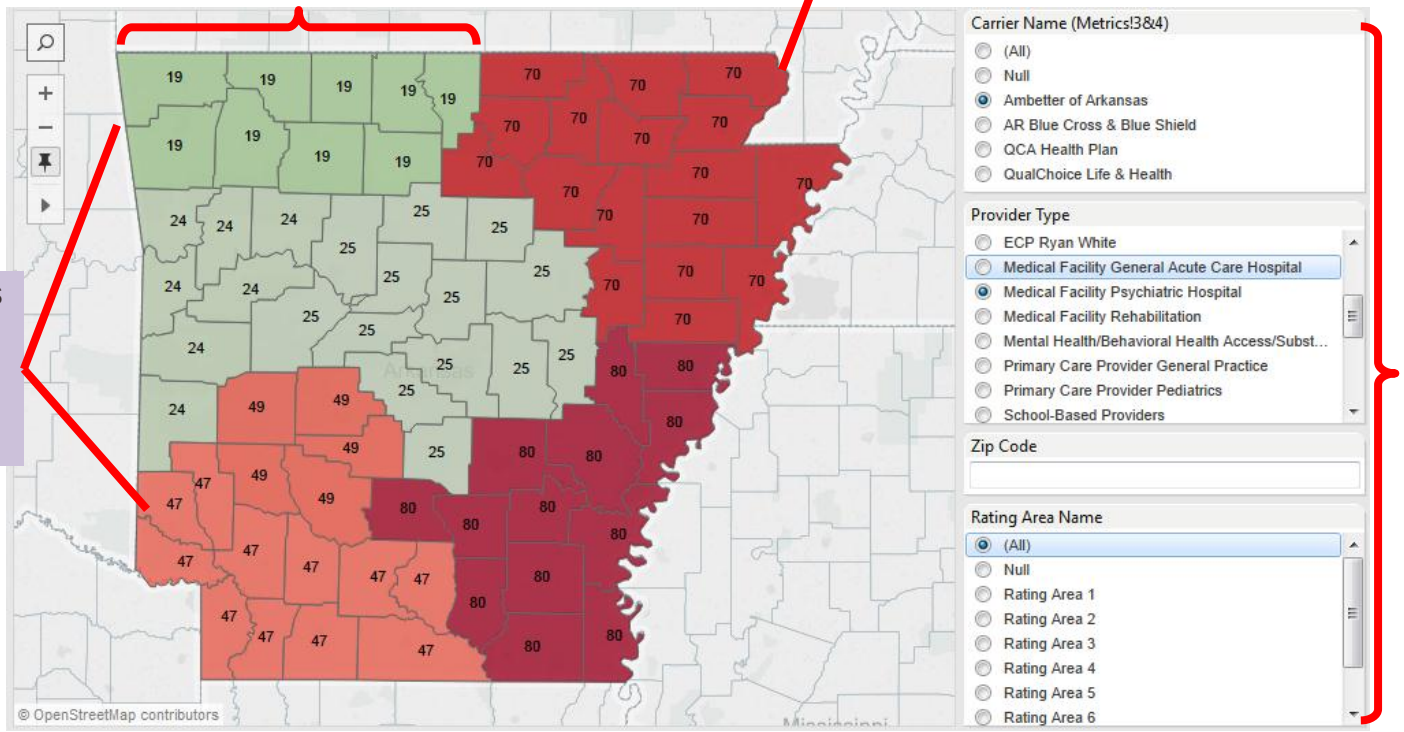
Concept: Average Distance to Provider

The average distance to an in-network provider describes geographic availability of providers for a carrier.

"19" = Average mileage from network enrollee to closest provider

Mileage is calculated based on major care use regions

Coloring reflects levels of compliance with network access standards



Mileage information is available for over 20 provider types

While mileage is calculated within a care region in Arkansas, out-of-state providers or providers in surrounding counties outside of the care regions can be included in the mileage calculations.

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Access: Provider-to-Enrollee Ratios

Provider-to-Enrollee ratios provide an alternative measure of access by addressing the capacity of a network to provide services to the enrolled population.

This measure is calculated using key fields in the Specialty Access Templates, and is reported at the county level for each issuer, network, and provider specialty. Provider-to-enrollee ratios are available for each of the 24 provider specialties for which AID measures access as part of the network adequacy review.

Provider-to-Enrollee ratios are dependent upon several factors that may influence the calculation's outcome, which can be mitigated through adjustments or enhancements to ratio reporting.

Item	Impact	Correction
Measure does not Address Acceptable Levels of Capacity	A ratio may appear high, but enrollees do not face any true barriers to receiving services	Baseline acceptable ratios according to national standards or averages across carriers
Ratio Depends on Carrier Enrollment	Low-enrollment carriers may appear to offer more access	Baseline acceptable ratios according to national standards or averages across carriers
Ratio Reports all Contracted Providers	Ratio does not tell whether providers are accepting new patients	Add data element / source of information about whether providers are accepting new patients

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Quality: Hospital CAHPS Survey

HCAHPS surveys hospital patients on their hospital experience in 11 categories:

1. Nurse communication;
2. Doctor communication;
3. Responsiveness of hospital staff;
4. Pain management;
5. Communication about medicines;
6. Cleanliness of hospital environment;
7. Quietness of hospital environment;
8. Discharge information;
9. Care transition;
10. Overall rating of hospital; and
11. Willingness to recommend hospital.

Consumers will filter results for a certain geographic area or hospital

Survey results are presented into three main formats:

1. **Score by Experience Category** — Each hospital receives 11 scores based on favorable survey results for each category; AR and national average will also be displayed
2. **Star Rating by Experience Category** — Each hospital receives 11 star ratings (1-5 stars) based on survey results for each category
3. **Summary (Composite) Star Rating** — Each hospital receives a single star rating (1-5 stars) based on survey results

Data Source: CMS Hospital Compare (HCAHPS) - Hospital Dataset; National Dataset; State Dataset

- Other Business
- Next meeting July 12, 2016