VHCURES: Where has it been? What can it do? Where is it going?

Presented to House Health Care Committee

January 28, 2014

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VHCURES: Vermont Health~~care~~ ~~Claims~~ Care Uniform Reporting & Evaluation System

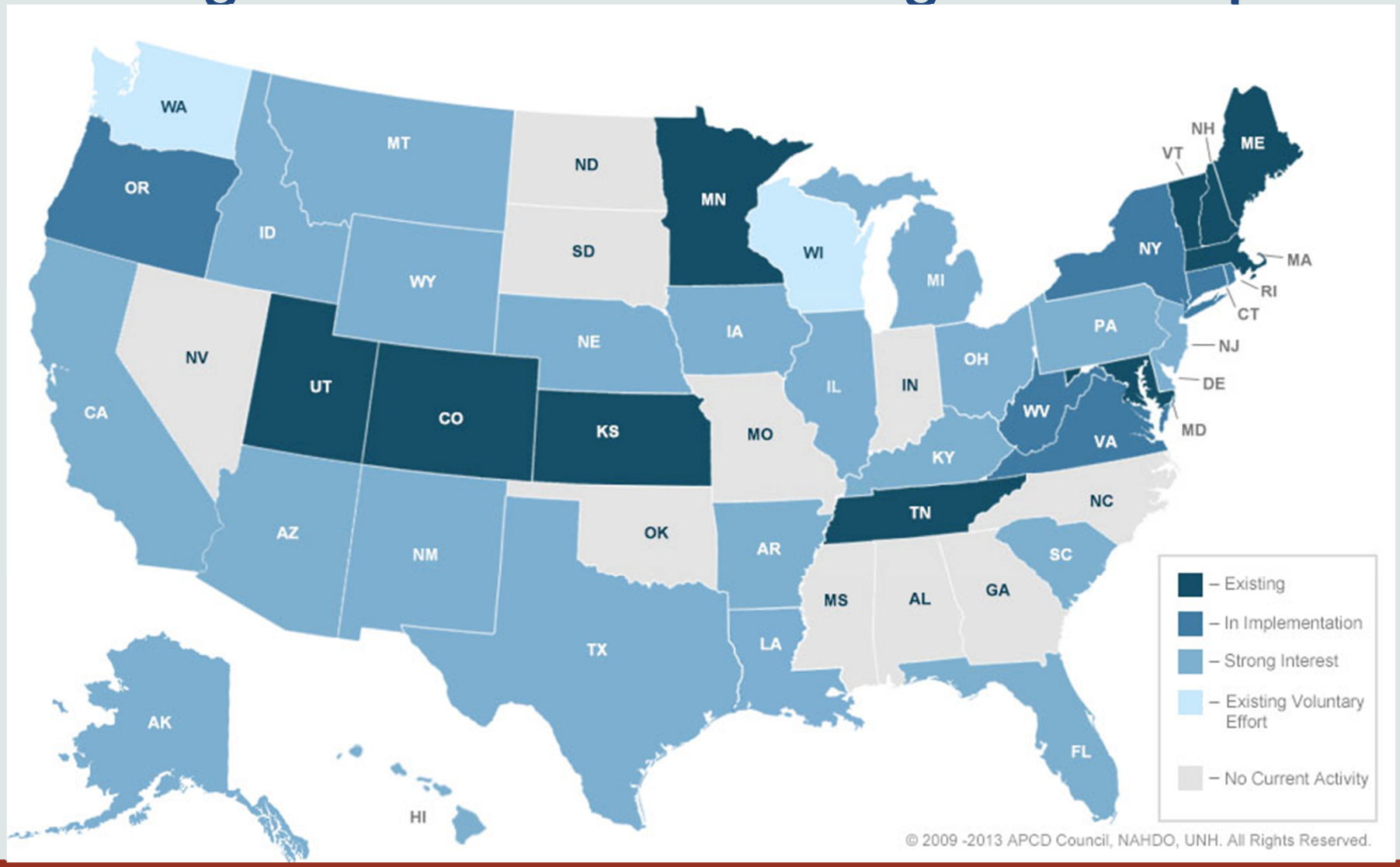
Claims-> Care in VHCURES concept?

- *Claims data are the core of VHCURES as an APCD (All Payer Claims Database). There is growing recognition that non-claims information (primarily financial) should be incorporated in APCDs to provide a more accurate picture of health care spending.*

What is an APCD?

Databases, created by state mandate, that typically include data derived from medical, pharmacy, and dental claims with eligibility and provider files from private and public payers:
Insurance carriers (medical, dental, TPAs, PBMs)
Public payers (Medicaid, Medicare) *- APCD Council*

August 2013 State Progress Map



VHCURES Snapshot

- *Statutory authority for VHCURES moved to GMCB as of July 2013*

- *As of 2014 (Inclusion of CMS Medicare Data by March 2014), VHCURES includes de-identified* eligibility records and medical and pharmacy paid claims for over 90 percent of the Vermont population. (*No names, no SSNs, no street addresses, no phone # in VHCURES)*

- *VHCURES is representative of Vermonters enrolled in public and commercial comprehensive health benefit plans. Commercial enrollment includes both insured and self-insured plans. VHCURES does not include dental insurers.*

- *VHCURES data warehouse has claims starting with 2007 and current through Q3 2013 for commercial and Medicaid. CMS Medicare data includes 2002- 2011 with 2012 update to follow in 2014.*

Who is missing from VHCURES?

- *Uninsured Vermonters (6.8% or 43,000)*
- *Federal Employees Health Benefit Plan (15,000 Vermonters; federal OPM exempt from state reporting mandates)*
- *Less than 2% of commercially insured (insurers with VT enrollment under 200 are exempt from VHCURES reporting requirement)*

VHCURES Milestones: Data Resource

BISHCA/DFR 2008 - June 2013

GMCB July 2013- current

- 2008- Reg H-2008-01 adopted addressing reporting requirements and data release process.
- 2009- Vendor procurement through competitive bid. Started collection of commercial insurance data starting with incurred service date of January 1, 2007 through current. Gaining insurer compliance on data submission and data quality took much effort for first 2 years of program and is ongoing to a lesser degree.
- 2010-2011- CMS approved memorandum of agreement between BISHCA and DVHA to allow integration of Medicaid data. DVHA works with BISHCA to map Medicaid data to VHCURES format and begins monthly data submissions.
- 2012- CMS grants BISHCA a data use agreement (DUA) to include Medicare data in VHCURES but use is solely limited to Blueprint under CMMI grant. VHCURES staff participates in national work group of states and CMS to develop "broad use" Medicare DUA for state agencies.
- 2013- After an extensive application process, CMS granted GMCB a State Agency Broad Use DUA with discretion to re-disclose the VT beneficiary Medicare data to other VT state agencies and authorized state contractors. VT is among first three states given a broad use DUA. Data are being processed and mapped to VHCURES format and will be available March/April 2014.
- 2014- VHCURES is finally All Payer!

VHCURES: To whom are the data available?

Statutory charge for availability of claims data: *To the extent allowed by HIPAA, the data shall be available as a resource for insurers, employers, providers, purchasers of health care and state agencies to continuously review health care utilization, expenditures, and performance in Vermont.*

Two Types of VHCURES Data Use Agreements and Data Release Protocols include Vermont State Agencies and Non-state Entities.

1. Vermont State Agencies (including authorized state contractors)

- VT state agencies file applications and data user affidavits for every user including agency employees and contractors' employees. DUA signed by GMCB for commercial and Medicare data and by DVHA for Medicaid data.
- State agencies may receive updated quarterly "comprehensive standard state data extracts." Each licensed agency approves how the data may be used for state contract work. State Agency DUAs are "broad use" and "evergreen" supporting flexibility for SOV users.
- State Agencies with VHCURES DUAs: AOA, AHS, DFR, DMH, DVHA, GMCB, JFO, OVSA, VDH

VHCURES: To whom are the data available?

2. Non-state Entities (Entities outside VT state government)

- File VHCURES application for "limited use research data set" that must be approved by GMCB for commercial insurer data. Requests to use Medicaid data must be approved by AHS IRB Review Committee. Per CMS DUA, Medicare data may not be re-disclosed to non-state entities.
- "Limited use" as opposed to "broad use" means that non-state entities must specify the exact research purpose and justify the use of each data element requested. Approved data extracts are limited to a subset of approved data elements.
- Non-state entity DUAs specify retention periods as opposed to "evergreen" DUAs granted to VT state agencies.
- Non-state entities with current VHCURES DUAs:

  The Dartmouth Institute- Dartmouth Atlas of Pediatric Health Care in Northern New England; Total Cost of Care Study

  Health Care Cost Institute- Collaborative Benchmarking Project with GMCB

  UNH New Hampshire Institute for Health Policy & Practice – Evaluation of use of claims data for public health reporting

How has the State of Vermont been using VHCURES data?

Health Care Reform Commission

Act 128 Hsiao Report

HIT Reinvestment Fund, Health Care Claims Assessment -> Health Care Claims Tax

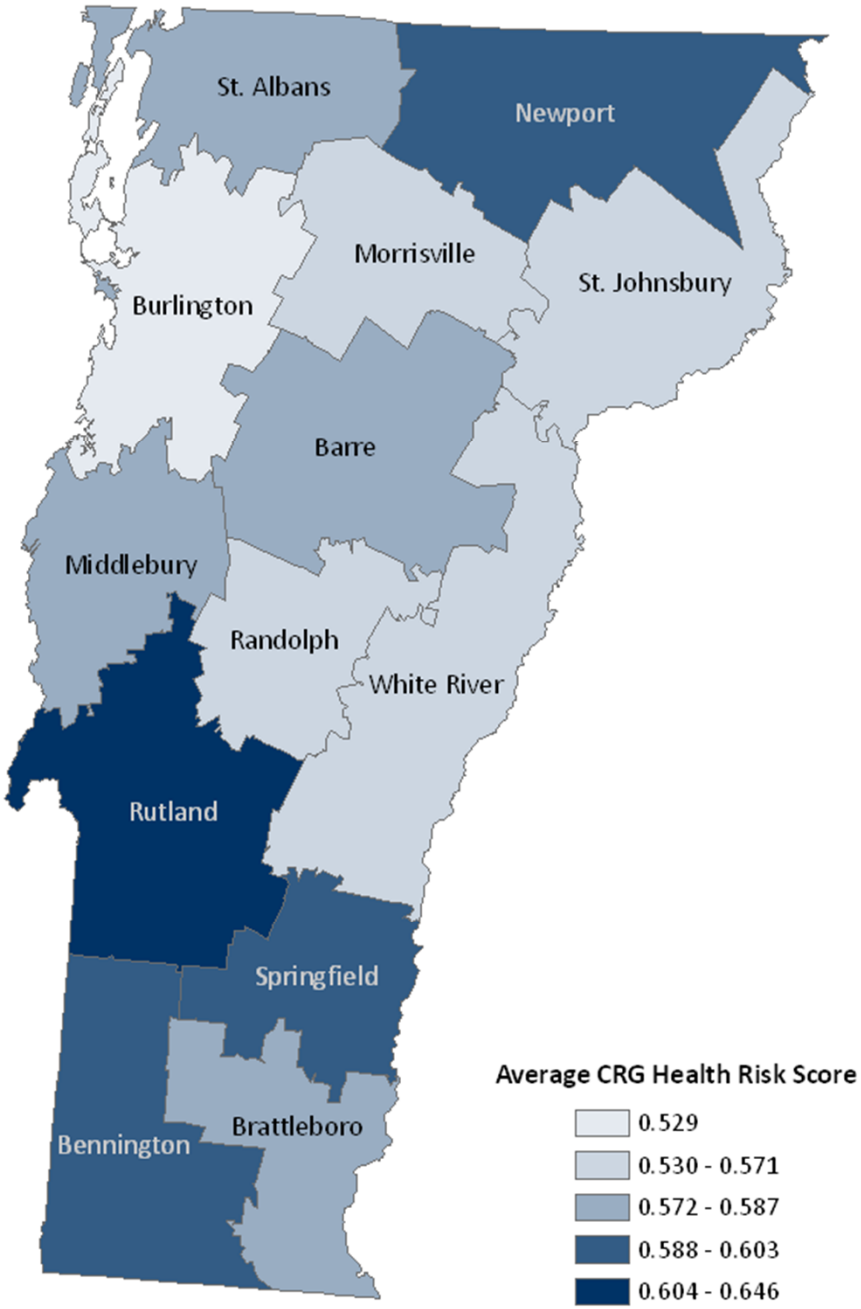
Annual Paid Claims & Enrollment Report initially used as basis for assessments and currently by Department of Taxes for purpose of auditing insurer tax filings.

BISHCA/DFR prior to VHCURES transfer to GMCB

Annual Standard Report Series (2007-2010): Healthcare Utilization and Enrollment Report and Report Card Series with commercially insured statistics by insurer and by service area

Tri-State Variation in Health Services Utilization & Expenditures in Northern New England (2010): Comparison of utilization and payment statistics for VT, NH, ME commercially insurer populations

Spatial Analysis Study: The Development of Primary Care Service Areas for the State of Vermont (2013)

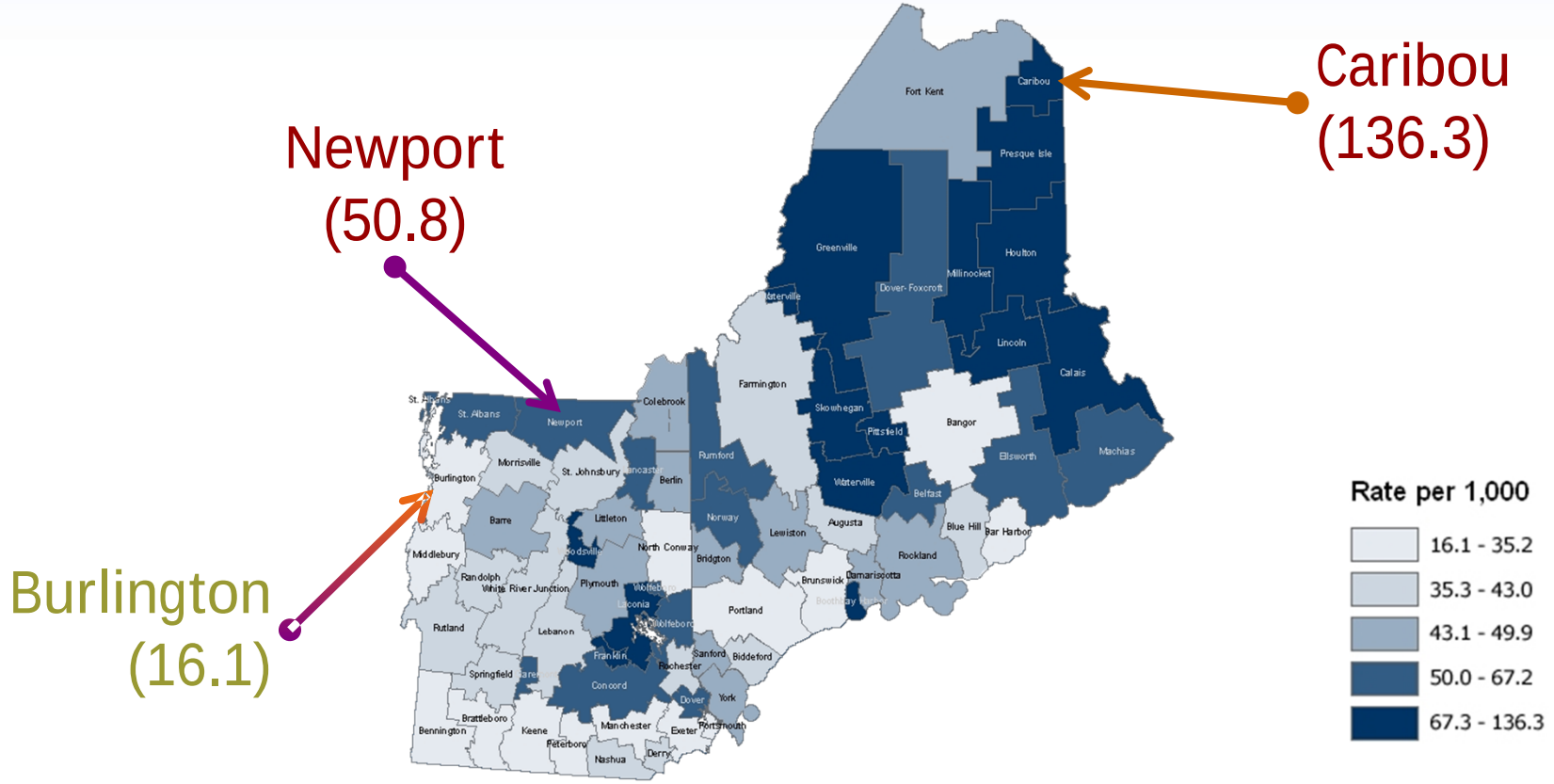

St. Albans
Newport
Morrisville
St. Johnsbury
Burlington
Barre
Middlebury
Randolph
White River
Rutland
Springfield
Brattleboro
Bennington
Average CRG Health Risk Score
0.529
0.530 - 0.571
0.572 - 0.587
0.588 - 0.603
0.604 - 0.646

Prevalence of Disease (Rates per 1,000 Vermont Commercial Members)

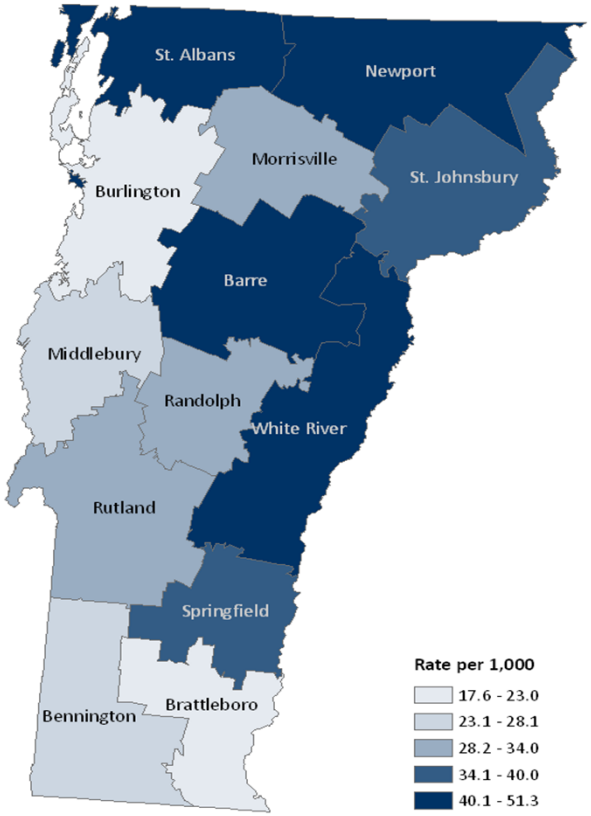
DISEASE CATEGORY	22222008	2009	2010	TREND 2009–2010	2010 COUNT
DISEASE CATEGORY	**2008**	**2009**	**2010**	**TREND 2009-2010**	**2010 COUNT**
Back Injury	142.1	147.9	155.1	+5%	47,277
Depression	75.9	82.2	88.4	+8%	25,811
Diabetes	42.0	43.9	44.1	+1%	12,892
Asthma	46.4	50.9	52.0	+2%	15,199
Coronary Heart Disease	17.1	18.7	17.6	-6%	5,136
Breast Cancer	6.6	7.0	7.0	0%	2,034
Chronic Obstructive Pulmonary Disease (COPD)	9.9	10.5	10.2	-2%	2,992
Stroke	6.1	6.6	6.4	-2%	1,877
Colorectal Cancer	1.3	1.4	1.5	+7%	441
Lung Cancer	1.1	1.1	1.1	+3%	328
CRG Risk Score	0.53	0.55	0.57	+3%	N/A

Tri-State Variation in Health Services

Outpatient Use – Potentially Avoidable Outpatient ED Visits

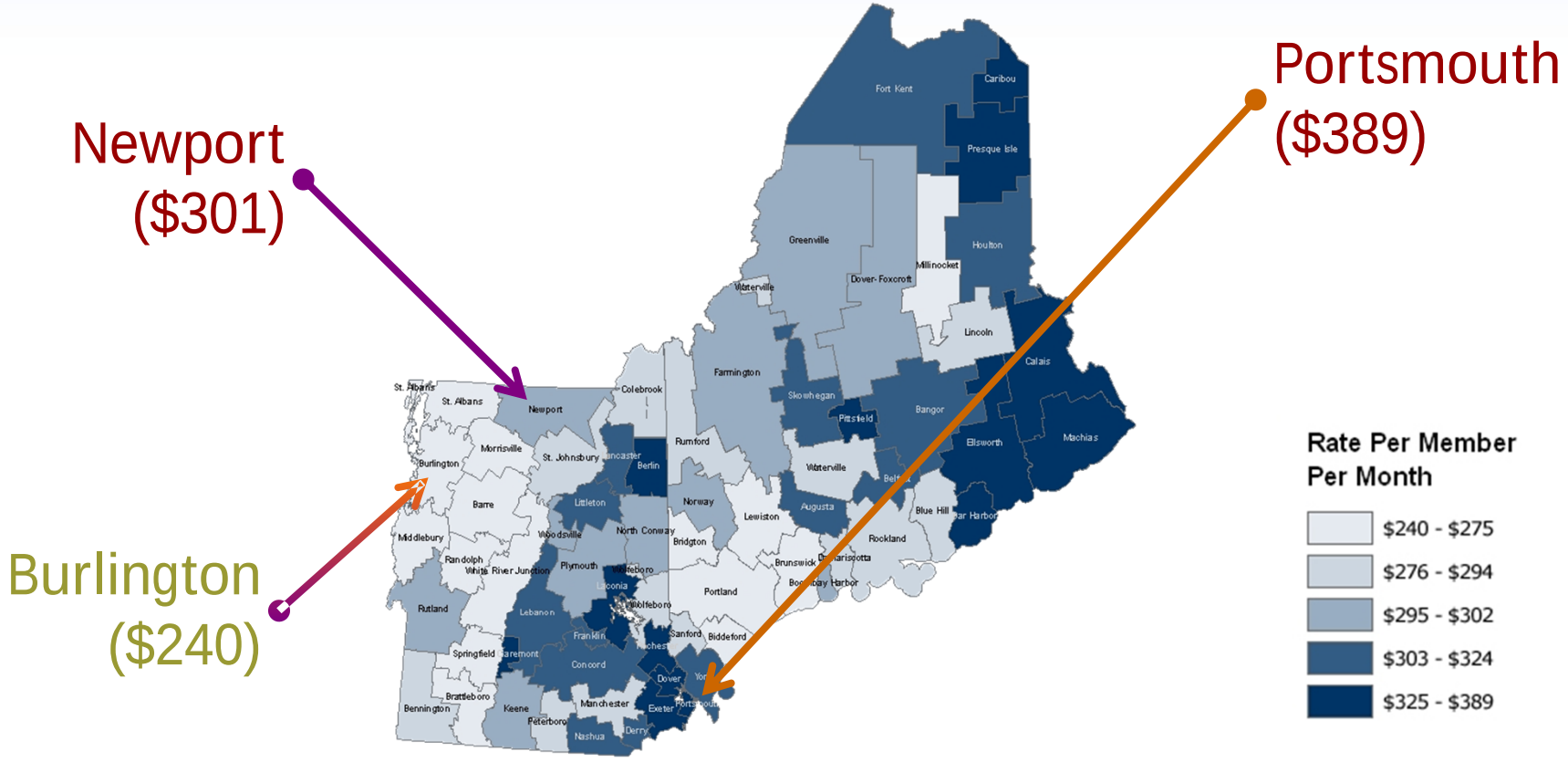


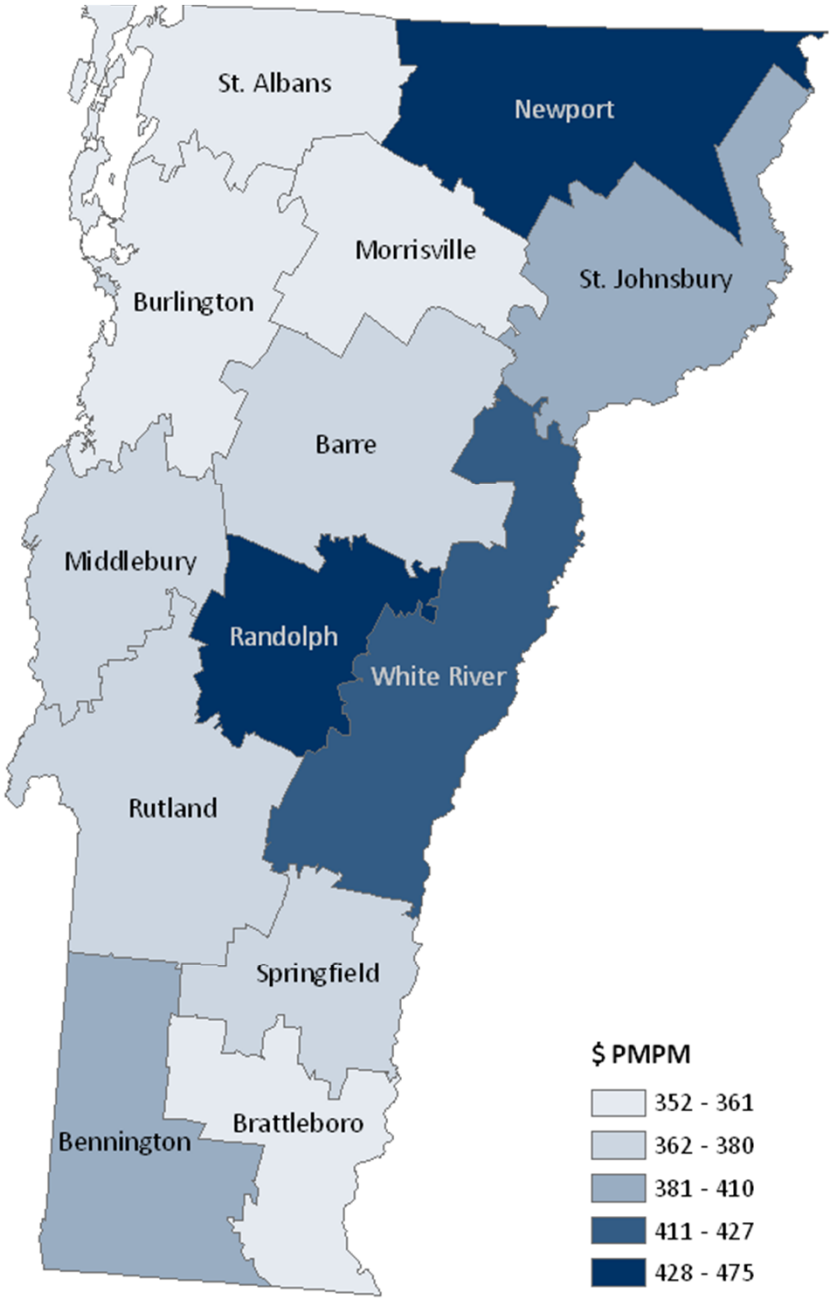
Rate of Potentially Avoidable Outpatient ED Visits by Hospital Service Area (Vermont Commercially Insured, 2010)



Tri-State Variation in Health Services

Expenditures – Medical Payments PMPM




St. Albans
Newport
Morrisville
St. Johnsbury
Burlington
Barre
Middlebury
Randolph
White River
Rutland
Springfield
Brattleboro
Bennington
$ PMPM
352 - 361
362 - 380
381 - 410
411 - 427
428 - 475

Utilization by Type of Service (Rates per 1,000 Vermont Commercial Members)

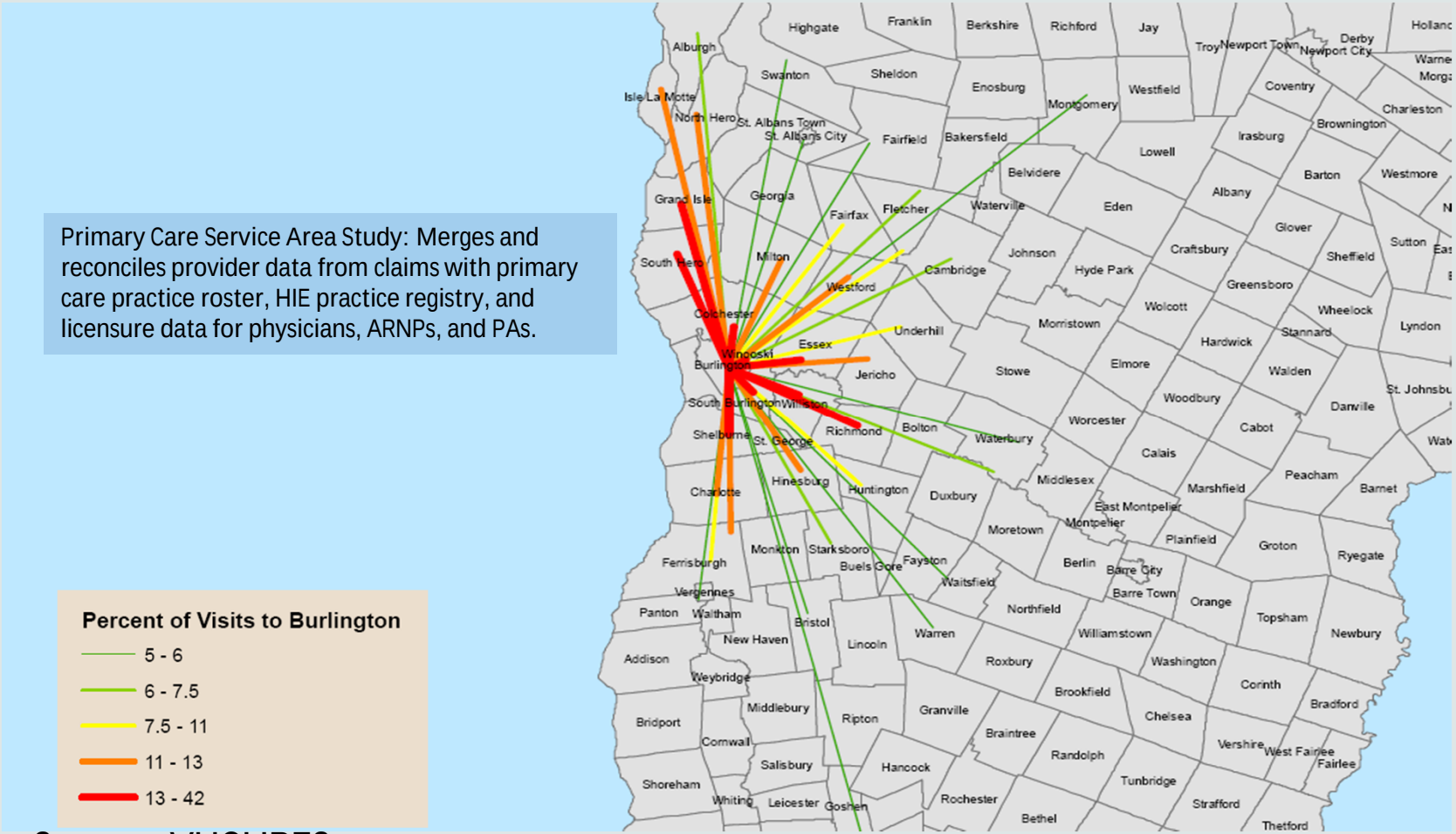
TYPE OF SERVICE	2008	2009	2010	TREND 2009–2010	2010 COUNT
Inpatient Measures	2008	2009	2010	Trend 2009-2010	2010 Count
Discharges	47.7	47.5	47.4	0%	13,847
Inpatient Days	192.4	197.5	202.2	+2%	59,036
Readmissions within 30 Days	4.9	4.8	4.8	+1%	1,415
Admissions for ACS Conditions	3.0	3.2	3.1	-2%	914
Other Selected Measures					
Outpatient ED Visits	192.4	187.5	184.9	-1%	53,979
Potentially Avoidable ED Visits *	31.4	31.6	30.0	-5%	8,773
Outpatient OR Procedures	86.6	88.2	90.9	+3%	23,534
Primary Care Encounters	2,643.7	2,726.3	2,649.9	-3%	773,792
Chiropractic/Osteopathic	643.6	638.6	642.3	+1%	187,547
Mental Health/Substance Abuse	913.0	967.2	993.5	+3%	290.110
Testing					
Advanced Imaging	138.0	136.8	136.3	0%	39,812
Standard Imaging	583.1	585.0	583.3	0%	170,335
Echography	187.4	193.7	197.9	+2%	57,776
Cardiac Testing	146.4	143.9	149.3	+4%	43,590
Pharmacy					
Rx Brand Use (30-Day Equivalents)	4,420.2	4,369.0	3,832.6	-12%	1,231,509
Rx Generic Use (30-Day Equivalents)	8,735.8	9,769.5	10732.4	+10%	3,134,007

% of Each Vermont Town's Primary Care Visits to Burlington

49.6% of Burlington member visits (05401 Zip Code) were to providers in the 05401 Zip Code.

These data (05401 to 05401) cannot be shown using a spider diagram.

Primary Care Service Area Study: Merges and reconciles provider data from claims with primary care practice roster, HIE practice registry, and licensure data for physicians, ARNPs, and PAs.



Source: VHCURES

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How has the State of Vermont been using VHCURES data?

Agency of Administration

Health Care Reform Financing Plan: Act 48, Section 9 (January 2013)

Department of Vermont Health Access

Blueprint for Health evaluation and statistics (RTI, Onpoint)

Other reform activities (Wakely Consulting, Burns & Associates, Global Health Payment LLC)

Green Mountain Care Board

Expenditure Analysis, Cost Drivers, Health Analysis Populations, Special Studies (Truven Health Analytics, Policy Integrity LLC)

SIM Evaluation of Payment Reform Pilots (near future)

Forecasting Tool (Wakely Consulting)

Price Variation Study I and II (VAHHS-NSO, UVM)

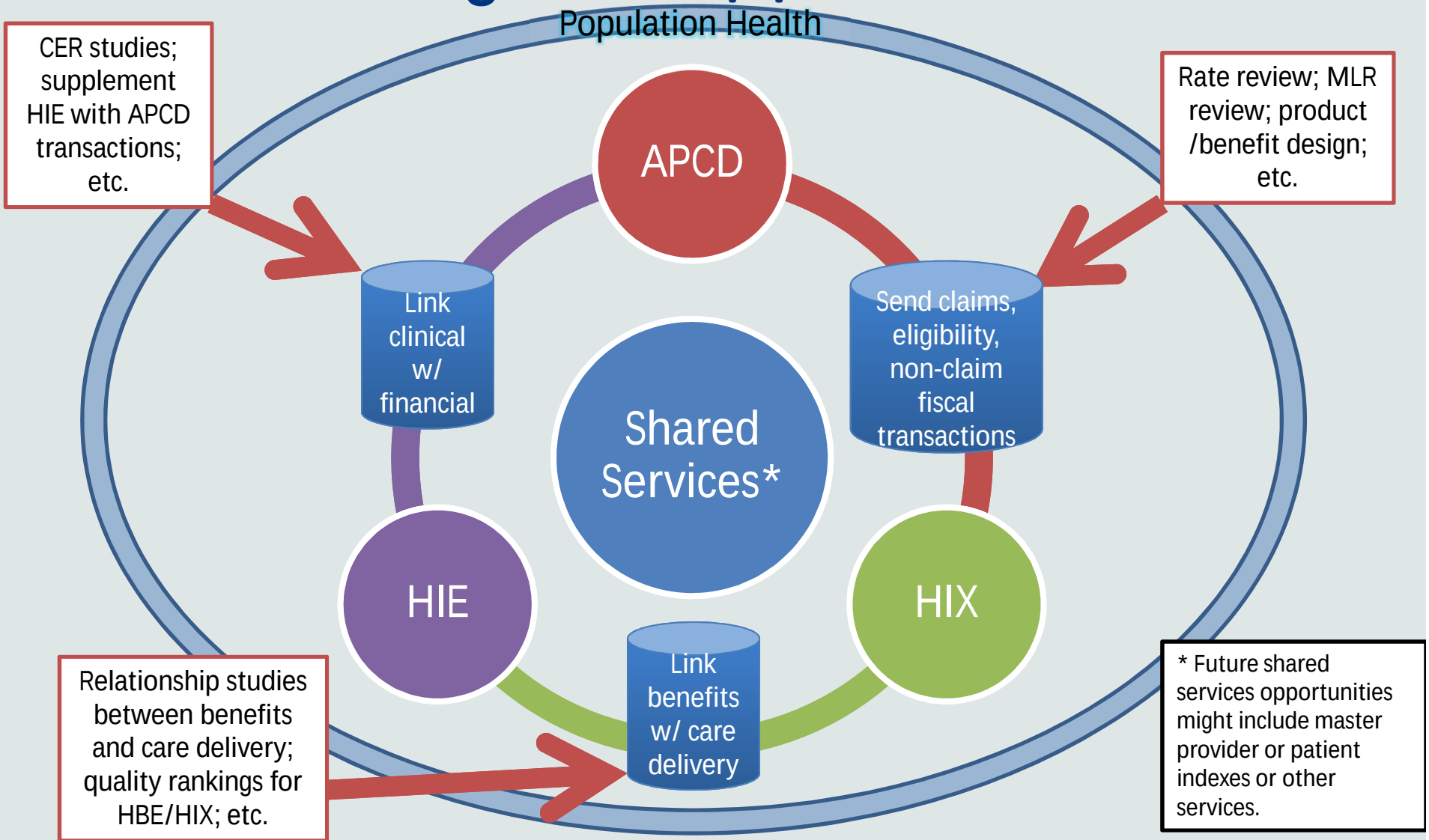
Department of Health

State Asthma Program and ASTHO/CDC grant-funded activities related to cardiac disease (planning stage)

APCDs and Health Reform

- Population health evaluation
- Prevalence measures
- Utilization and spending
- Quality measures
- Risk stratification for chronic conditions
- Risk adjustment
- Rate review audits
- Consumer engagement
- Employer engagement

Strategic IT Opportunities



APCD Opportunities with HIE* & HIX

HIE

- Calculating Fiscal Impact of Clinical Decision-Making and Comparative Effectiveness
- Public Health Research
- Health Services Research
- Risk Adjustment and Episodic Analyses
- Populating the HIE With APCD "Non-Clinical Events"
- TBD…

HIX

- Rate Review
- Risk Adjustment
- Medical Loss Calculations
- Product Design
- Benefit Design
- Quality Metrics Integration
- TBD…

* Or Other Clinical Repositories Such As Registries or Electronic Health Records.

Price Transparency Drivers

- Policymakers:
  - Identify high performing communities & cost effective care
  - Benchmark Medicaid payments/utilization
  - Validate carrier rate filings
- Employers
  - Forecast health care costs
  - Top providers, services by cost
- Inform Consumers
  - Out of pocket cost increases stimulates demand for information

Price Transparency Challenges

- Legal protection or rates negotiated between providers and payers
- Linking cost with quality
- Provider Identifiers with a lot of “noise”
- Attribution methodology
- Concerns about ‘unintended’ consequences
  - Increased in payments

Price Transparency Facilitators

- At the minimum, publishing pricing information advances conversations about health care costs
- Rising out-of-pocket costs stimulate consumer interest
- State APCDs laying the groundwork: Maine and New Hampshire Health Cost Websites

Building a better VHCURES

GMCB took on VHCURES in July 2013 with multiple program and operational changes underway to improve VHCURES.

VHCURES 2.0 will build on strengths, improve on weaknesses, and look towards a future of data integration across agencies and data sources to support analytics needed to measure, monitor, and evaluate population health, health care reform activities and impacts on health care resources, spending, and outcomes.

VHCURES improvements must support GMCB-related analyses *by ensuring that the "state has the appropriate tools and information to accurately track changes in key indicators of progress toward the goals of Act 48.*

- Annual Report of the Green Mountain Care Board, January 15, 2014

GMCB VHCURES Improvement Activities

Interagency Data Governance Structure to identify and prioritize changes to the program, operations, and data resource to meet broader state needs for information and analytics

Rule Amendment to update reporting requirements to improve the utility of the data to support analytics and research needed to understand more about population health, health care system performance, and impacts of activities to reform and transform the system.

Competitive Bid/Vendor Procurement (current contract expires August 2014) for data processing and transformation and data user support services to improve the utility, quality, security, and accessibility of the data resource for diverse users.