Vermont State Auditor

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Report to the Green Mountain Care Board

VHCURES: Past, Present, and Future

Opportunities for Health Care Price Transparency and Greater Consumer Information

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Mission Statement

The mission of the Vermont State Auditor's Office is to hold government accountable. This means ensuring taxpayer funds are used effectively and efficiently, and that we foster the prevention of waste, fraud, and abuse.

Principal Investigator

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Non-Audit Inquiry

This is a non-audit report. A non-audit report is an effective tool used to inform citizens and management of issues that may need attention. It is not an audit and is not conducted under generally accepted government auditing standards. A non-audit report has a substantially smaller scope of work than an audit. Therefore, its conclusions are more limited, and it does not contain recommendations. Instead, the report includes information and possible risk-mitigation strategies relevant to the entity that is the object of the inquiry.

EXECUTIVE SUMMARY

For the last five years, the State of Vermont has been developing a powerful database that sheds light on price trends and variation across Vermont's health care providers. The Vermont Health Care Uniform Reporting and Evaluation System (VHCURES) is an all-payer claims database that includes information about claims paid by commercial insurers, Medicaid, and Medicare. It is a digital catalogue of all fees for medical services and products that insurers paid over the last seven years for Vermont residents.

Meanwhile, Vermonters have become increasingly responsible for paying a larger share of health care costs, as enrollment in high-deductible health plans rose from 21 percent of the state's commercial market in 2009 to 34 percent in 2012.[1] While patients are given a greater incentive to make decisions based on the cost of care, they are not given the information necessary to effectively weigh their options. VHCURES can be used to pinpoint the actual cost of health care for an individual patient, based on a particular plan and provider.

What providers charge and what insured patients and their insurers pay for medical services often bear little resemblance. The amount that an insured patient actually pays for a service will vary based on the rate that an insurer negotiates with a specific provider. VHCURES can be used to show the negotiated rate for a specific service from a specific provider, what the insurer paid for that service, and what portion of that rate the patient was liable for. VHCURES also includes charge data, which is what uninsured patients are liable for paying if they don't obtain provider discounts or assistance.

The State Auditor's Office (SAO) initiated an inquiry into VHCURES to assess, in part, the extent to which the database could be used to provide greater transparency of health care costs and to better inform consumers of the price of specific medical procedures. The Legislature charged the board with this responsibility, and Vermont physicians have articulated a desire to make this information available to clinicians and patients. While the State has made no such effort to date, the SAO found strong evidence to suggest it is feasible for the State – or possibly another third party – to use VHCURES, or claims data, to provide patient-specific price information and better inform Vermont's insured and uninsured populations.

Neighboring states, such as New Hampshire, have shown that a claims database can be used to provide consumers with price estimates for services and products. While a thorough validation of VHCURES data would be necessary to ensure the information's reliability, an SAO analysis with a Green Mountain Care Board contractor showed that VHCURES could be used to compare health care prices. Additionally, a legal analysis at the end of this report by the Vermont Attorney General's Office addresses anti-trust concerns surrounding provider price transparency. As Vermont providers and insurers test new payment models, they plan to exchange claims data at an unprecedented level.

[1] Vermont Department of Financial Regulation Insurance Division, *The Commercial Health Insurance Market in Vermont*, 2013, 8-11. See the report.

Numerous insurers and private entities across the country have also created tools to help consumers shop for health care. Some of these examples suggest that the State of Vermont could work more effectively with insurers to better provide comparable price estimates to consumers.

An SAO literature review of recent research on health care price transparency boiled down to three useful points for Vermont policymakers and program managers. First, price information is more helpful when paired with quality information because research shows that price and quality are not synonymous in health care. Second, patients appear to care more about health care prices when they share more of the cost. Third, consumer information is most useful for care that is non-urgent and can be planned.

The SAO's inquiry also sought to determine how VHCURES had been used in the past and is being used at present. After a detailed review of all data use agreements, contracts related to VHCURES, a range of work products, numerous interviews, and several data demonstrations, the SAO has concluded that VHCURES has been used to fulfill five of the six statutory duties for which it was created. The remaining statutory charge, which the Green Mountain Care Board and its predecessors have not addressed, is using VHCURES to inform "consumers and purchasers of health care."[2]

The last SAO objective for this inquiry into VHCURES was to identify what plans are in place for a new version of the database. The Green Mountain Care Board is preparing to overhaul VHCURES, with the chief goal of better tracking individual patients as they move through Vermont's health care system (the current system does not include personal identifiers). While the Statement of Work for the transition from the current system does not mention consumers or consumer information, among numerous changes to the database, the board states in an appendix to its 2014 Annual Report, "We will explore the feasibility of using VHCURES … as a means to provide cost information to Vermonters."[3] To date, providing consumers with price and quality information has not been a priority for the GMCB, which has limited resources to oversee a large slate of health care reform initiatives.

BACKGROUND

The Vermont Health Care Uniform Reporting and Evaluation System (VHCURES) is an all-payer claims database that includes information about claims paid by commercial health insurers, Medicaid, and Medicare. It is a digital catalogue of all fees for medical services and products that insurers paid over the last seven years in Vermont. This trove of information provides the State an unprecedented opportunity to inform lawmakers, program managers, health care providers, and patients.

VHCURES was created in 2009 pursuant to Vermont law 18 V.S.A. §9410 and in accordance with Regulation H-2008-01 of the former Department of Banking, Insurance, Securities and Health Care Administration (BISHCA) – restructured as the Department of Financial Regulation (DFR), with some of BISHCA's key health care responsibilities shifted to the newly formed Green Mountain Care Board

[2] See: 18 V.S.A. §9410 (a)(1).

[3] Green MountainCare Board, *Annual Report to the General Assembly*, 2014, 34. Read the Annual Report.

(GMCB). The database is composed of more than 100 million commercial and public insurance claims, including those for both medical procedures and pharmaceuticals, dating back to January 2007. The database is sorted into hundreds of fields and populated with information solely from insurance claims paid for Vermont residents, who received care in and out of state.[4]

VHCURES includes data for roughly 90 percent of the commercially insured and 100 percent of Vermonters covered by Medicaid and Medicare,[5] and it only includes information for paid claims. The database does not include denied claims, partially processed claims, and bills charged to or paid by the uninsured.[6] It does not include the roughly 15,000 Vermonters insured by the Federal Employees Health Benefit Plan and some other plans for federal employees. It also does not include the claims of commercial insurers with fewer than 200 Vermont members.[7]

The GMCB has been fully responsible for maintaining VHCURES since July 2013. The board is statutorily charged with this duty for the six chief purposes of:

1. Determining the capacity and distribution of existing resources;
2. Identifying health care needs and informing health care policy;
3. Evaluating the effectiveness of intervention programs on improving patient outcomes;
4. Comparing costs between various treatment settings and approaches;
5. Providing information to consumers and purchasers of health care; and
6. Improving the quality and affordability of patient health care and health care coverage.[8]

The board contracts to Maine-based OnPoint Health Data to manage the collection, organization, and distribution of VHCURES data. Commercial insurers must report their claims data to the State's managing vendor on an annual, quarterly, or monthly basis, depending on the number of members they insure.

Names of the insured, their social security numbers, their insurance contract numbers, and other member identifiers are encrypted by commercial insurers and the Vermont Medicaid program before the data are submitted to OnPoint.[9] The vendor then encrypts this data again. [10] OnPoint uses a two-way encryption algorithm for Medicare data, which encrypts identifiers when they are uploaded to the vendor's system.[11]

The State previously required claims data from third-party administrators of self-funded company plans, which are allowed under the Early Retirement Income Security Act (ERISA). A recent U.S. Court of Appeals decision concluded that ERISA preempts the State from mandating self-funded plans to report

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4 Department of Financial Regulation, *Data Dictionary for the Vermont Healthcare Claims Uniform Reporting and Evaluation System,* 2013.

5 This finding is based on a GMCB analysis of several sources. Please see page 25 of Appendix C.

6 BISHCA, *Regulation H-2008-01,* 2008, 9.

7 Dian Kahn, VHCURES: Where has it been? What can it do? Where is it going?, 2014. See the presentation.

8 See: 18 V.S.A. §9410 (a)(1).

9 OnPoint Health Data, *APCD Technical Specification - Encryption Methodology*, 2012.

10 Standard Contract for Services with OnPoint Health Data #20229, 2011, 6.

11 CMS and Green Mountain Care Board Data Use Agreement, Version 8/2012, 4.

this information.[12] The State is petitioning the court for a re-hearing, and, in the meantime, state officials are asking self-funded entities to voluntarily submit claims data to the State. The 2012 Vermont Household Health Insurance Survey found that an estimated one-third of Vermonters with private insurance, or 110,106 lives, are covered by self-funded plans.

History of VHCURES

When the legislature created the Vermont Health Care Authority in 1992, it charged the three-member board with the chief responsibility of containing health care costs while maintaining and improving quality of care.[13] To inform the Authority's efforts, the legislature called on the board to establish a unified health care database, which would house information from health insurers, health care providers, health care institutions, and government agencies.[14]

The idea, as outlined in Act 160, was to create a resource that could help the Authority assess the capacity of Vermont's health care system, evaluate state programs, and identify health care needs. The database was also meant to help the Authority compare costs and provide information to consumers.

By 1992, the State had roughly two decades of experience collecting and analyzing hospital discharge records in what is known as the Vermont Uniform Hospital Discharge Data Set. John Wennberg, who was director of Vermont's Regional Medical Program, began the project in the early 1970s as a pioneer of health data management and analysis techniques.[15] These data provided (and continue to provide) information limited to hospital-based utilization and charges, but did not include the amounts paid for services. The new law, Act 160, called on the State to begin collecting and organizing price-specific claims data, which provide further insights into utilization and expenditure trends, as well as the actual rates that insurers pay providers and the amounts patients are liable for paying.

In 1996, the legislature passed Act 180, which dissolved the Health Care Authority and shifted its powers to the newly created Health Care Administration under BISHCA. Although the database called for in 1992 legislation did not yet exist, the power to create and maintain the database shifted to the newly formed Health Care Administration.[16] According to the GMCB, BISHCA worked with a few major insurers in the late 1990s to develop a prototype for a uniform claims reporting system. The voluntary effort was transient, and the Centers for Medicare and Medicaid Services (CMS) did not then support the contribution of Medicaid data for this project.

The 2005 appropriations bill, Act 71, required health insurers to provide electronic claims data to the commissioner of BISHCA. This was important because the collection of claims data from commercial

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12 United States Court of Appeals for the Second Circuit, *Liberty Mutual Insurance Company v. Susan Donegan,* 2014.

13 Act 160: An Act Relating to a Health Care Authority Sec. 1, 18 V.S.A. §9401-9413, 1992.

14 Ibid, 18 V.S.A. §1670.

15 John E. Wennberg, *Tracking Medicine: A Researcher's Quest to Understand Health Care*, Oxford University Press, 2010, 14-25.

16 Act 180: An Act to Coordinate the Oversight and Regulation of Health Care and Health Care Systems, 1996. Read the Act.

insurers was not previously mandated by law; it was up to the discretion of the commissioner. The legislation also required the commissioner, in collaboration with the Agency of Human Services, to develop a comprehensive health care information system.[17] The following year, the legislature expanded this language, calling on BISHCA to provide health care price and quality information to consumers.[18]

BISHCA created a rule to gradually implement a consumer information system before the database came to fruition. The rule, which took effect in 2008, placed the responsibility on insurers and providers to supply consumers with price and quality information.[19]

That year, BISHCA created a separate rule that laid the groundwork for VHCURES, a medical and pharmaceutical claims database. The State began working with insurers on this project and contracted to Maine Health Data Processing Center to begin developing the database.[20] In 2009, the State contracted to the private half of the center, OnPoint Health Data, to manage the collection, organization, and disbursement of VHCURES claims data. Vermont became one of the first ten states in the country to build this type of database, following Maine, Massachusetts, and New Hampshire.

In 2003, OnPoint – then called the Maine Health Information Center – and the State of Maine formed the Maine Health Data Processing Center to create the country's first statewide all-payer claims database. In 2005, New Hampshire contracted to OnPoint to collect and maintain claims data for its database, called the New Hampshire Comprehensive Health Care Information System.[21] Minnesota and Rhode Island have also contracted to OnPoint to help build claims databases.[22]

Before Vermont launched VHCURES, the New Hampshire Insurance Department began using its all-payer claims database to inform consumers of price information. In 2007, it launched the website NHHealthcost.org, which allowed consumers to compare the median prices of common procedures.[23] Maine quickly followed suit, creating Maine Health Cost,[24] and Massachusetts recently created a similar website.[25]

In 2010, CMS approved an agreement between the Department of Vermont Health Access (DVHA), which oversees the State's Medicaid program, and BISHCA to incorporate Medicaid data into VHCURES. In 2011, CMS approved the inclusion of Medicare data in VHCURES for the sole use of Vermont's Blueprint for Health initiative.[26] In 2013, CMS approved a separate data use agreement that allows the

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17 Act 71: An Act Making Appropriations for the Support of Government Sec. 312, 18 V.S.A. §9410 2005. Read the Act.

18 Act 191, an Act Relating to Health Care Affordability for Vermonters Sec. 57, 18 V.S.A. §9410, 2006. Read the Act.

19 BISHCA, *Rule No. H-2007-05: Health Care Price and Quality Transparency Rule,* 2007.

20 State of Vermont, Standard Contract for Services #12496 with Maine Health Data Processing Center, 2008.

21 See: New Hampshire Comprehensive Health Care Information System website.

22 See: The OnPoint clients' page.

23 New Hampshire Insurance Department, *The Impact of Price Transparency on HealthCost Services in New Hampshire*, 2009. Read the report.

24 See: The Maine Health Cost website.

25 See: The Massachusetts Health Care Quality and Cost Council website.

26 CMS-BISHCA Data Use Agreement #21696, 2011.

board to use Medicare data for state projects and gives the board discretion to distribute Medicare data to other state agencies and contractors performing work for the State.[27] OnPoint incorporated the Medicare data into VHCURES earlier this year.[28]

During VHCURES' formative years, the legislature shifted the bulk of BISHCA's Health Care Administration resources and responsibilities to the five-member GMCB, which has broad authority to regulate hospitals and health insurers.[29] Two years after the creation of the new regulatory body, the legislature moved responsibility for VHCURES to the board in July 2013.[30]

The board and its staff are gearing up for an overhaul of VHCURES in 2014 that is aimed at streamlining processes and better tracking patients as they move through the health care system. The board renamed the Vermont Healthcare Claims Uniform Reporting and Evaluation System in 2014 to the Vermont Health Care Uniform Reporting and Evaluation System, reflecting the transition to a more comprehensive data set that widens its focus beyond claims.[31]

INQUIRY OBJECTIVES

The SAO inquiry into VHCURES was driven by three objectives:

1) To determine how the all-payer claims database was used in the past and is used at present;
2) To identify what plans are in place for a new version of the database; and
3) To assess the extent to which the database could be used to provide greater transparency of health care costs and to better inform consumers of the price of specific medical procedures.

While our inquiry focused on VHCURES, we expanded our scope to other public and private transparency initiatives that drew from claims data.

The following three sections outline the SAO's findings.

OBJECTIVE 1: USE OF VHCURES

To understand how the database has been used in the past and is used at present, the SAO researched the various ways users gained access to VHCURES, including how the process has changed over time, and the interaction between state entities and outside contractors. To that end, our office reviewed all data use agreements and all identifiable contracts related to VHCURES. The office reviewed contractual deliverables, work products, and interviewed officials from all state agencies that have data use

[27] CMS-GMCB Data Use Agreement #25534, 2013.
[28] Dian Kahn, *VHCURES Overview and Status Report: October 9, 2013*, 2013. See the presentation.
[29] Act 48: An Act Relating to a Universal and Unified Health System, 2011. Read the legislation.
[30] Vermont Legislature, *Act 79: An Act Relating to Health Insurance, Medicaid, the Vermont Health Benefit Exchange and the Green Mountain Care Board Sec. 40 "VHCURES,"* 18 V.S.A. §9410, 2013. Read the Act.
[31] Testimony by Dian Kahn to the House Health Care Committee on Jan. 28, 2014.

agreements to access VHCURES. The office also met with select data users to view demonstrations of how they have worked with and analyzed the data.

The office used the statutory framework in 18 V.S.A. §9410(a)(1) to assess how VHCURES was used. The central finding of this section is that the database has been used to fulfill five of the six statutory duties associated with VHCURES. The remaining statutory charge the GMCB and its predecessors have not addressed is to provide information to consumers and purchasers of health care.

To outline the many uses of VHCURES, this section is broken into three main subsections:

1) Users and access;
2) State and non-state use; and
3) Management and maintenance

Users and Access

Since 2010, more than 250 individuals have been granted varying degrees of access to VHCURES data. The claims data are rich in information but contain many complexities. Although dozens of Vermont state employees are authorized to use VHCURES, many have not accessed the data, and even fewer have been able to work with them. Numerous state employees identified the lack of a user-friendly interface – such as a business intelligence tool for analytics – as a barrier to accessing and making full use of this data. The State previously worked with OnPoint in an attempt to develop an analytics tool, but the tool never came to fruition. Another obstacle that employees noted is the difference in coding for similar services and products. This is due to non-standard business practices across providers and insurers.

While the SAO identified at least one state employee who was proficient in using the public insurance data for analytical purposes, the SAO did not identify a state employee who was proficient in using the private insurance claims data. Staff at the GMCB noted that record-level users must be highly trained and educated to understand and work with this data, and the State of Vermont lacks employees who have this knowledge and ability.

Contractors are the chief users who organize and conduct deeper analyses of the data for the State.

To extract information from VHCURES, users employ computer programming languages, such as SQL and SAS.[32]

For an individual to gain access to VHCURES, he or she must be affiliated with an organization that has a data use agreement with the board. Previously, those agreements were with BISHCA and then the Department of Financial Regulation (DFR), which evolved from BISHCA.

In addition to the data use agreements, the State in 2011 began requiring individual data users to sign affidavits before granting access to VHCURES. The affidavits stipulate the legal parameters of using the

[32] This statement is evidenced by data user demonstrations.

database. Users are prohibited from disclosing and selling information that isn't authorized; they are required to report security incidents involving federal data; and they are required to delete or destroy their version of VHCURES after an agreement has ended.[33]

The State uses a different data use agreement application process for state and non-state entities. Non-state entities can apply for a limited use data set. This process requires applicants to supply a detailed outline of their research objectives and justifications for requesting the data. These entities can also gain access to Medicaid data with DVHA's permission. But, under the agreement that the board has with CMS, these entities are prohibited from accessing Medicare data.

Vermont state entities can apply for and obtain a "broad use" data use agreement that provides them access to both commercial and Medicaid data. CMS granted GMCB the discretion to approve releases of Medicare data to other Vermont state agencies and their contractors.

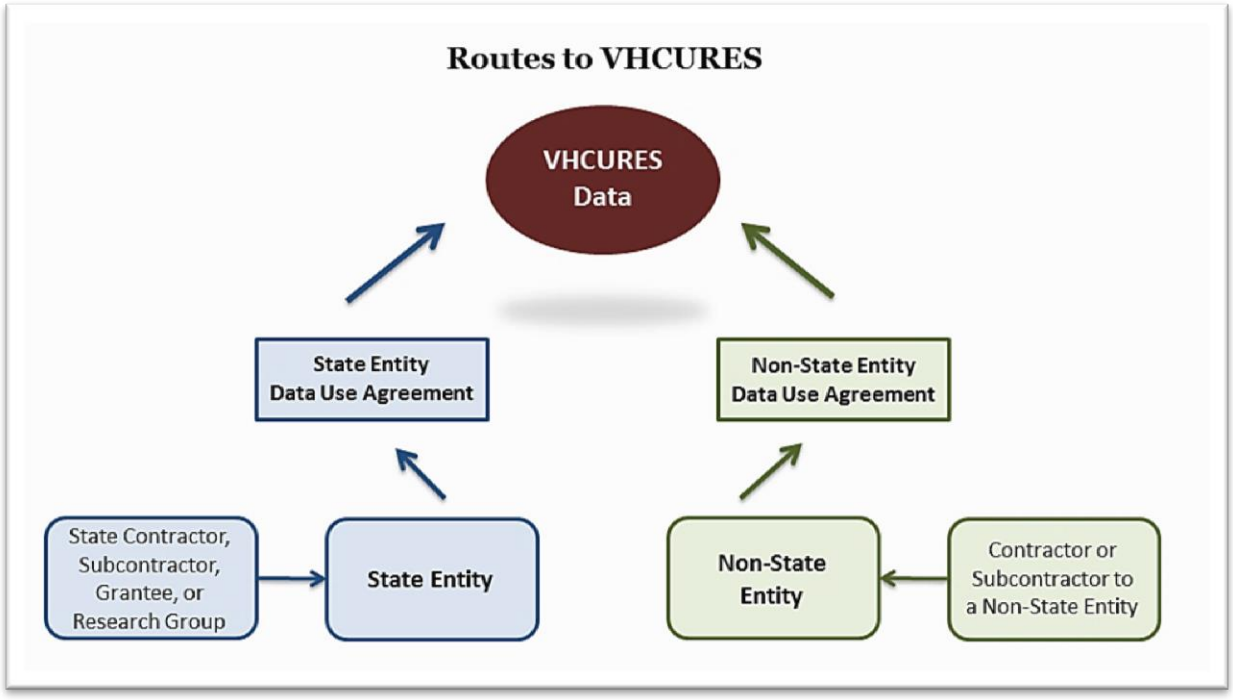
Non-state entities do not pay the State of Vermont for access to VHCURES, and the GMCB does not have statutory authority to charge for this data. Non-state entities do, however, pay an up-front fee of $5,200 to the State's managing vendor, OnPoint, for a customized data extract. State and non-state entities with access to VHCURES pay for each extract at a rate that varies between $515 and $5,200, depending on how the vendor processes the data.[34] New extracts, with updated data, are available each quarter.

The data use agreements are legal documents that bind an organization to use VHCURES data for the purposes specified in a VHCURES data use application. The agreements place the burden to abide by the board's conditions on the individual or individuals who sign the document – generally a requestor and/or principal investigator.

Organizations that sign data use agreements are not the only entities that have gained access to VHCURES. Contractors and other entities working with an organization that has a data use agreement have gained access to VHCURES through the organization's agreement. The figure below shows the main avenues that entities have taken to gain access to VHCURES.

[33] Green Mountain Care Board, *VHCURES Limited Use Healthcare Claims Research Data Sets: Data Users Affidavit*, 2013.

[34] OnPoint Health Data, *VHCURES Extract Cost Summary*, September 1, 2011 to August 31, 2014.



The above figure shows how different types of organizations have gained access to VHCURES data through Vermont's data use agreement process for state and non-state entities. The GMCB requires individual data users to sign an affidavit before using VHCURES on behalf of their organization.

To date, no individual insurance company has had access to the database. The only documented hospital that has been permitted access to VHCURES data is Northeast Vermont Regional Hospital, via DVHA's data use agreement. Trade associations representing hospitals and insurers have also gained access to VHCURES data.

While many providers may not have direct access to VHCURES in the future, they will have access to similar claims data. The CMS Medicare Shared Savings Program gives participating provider organizations, called Accountable Care Organizations (ACOs), access to their patients' Medicare claims data.[35] In addition, Vermont's Medicaid program and two commercial insurers are set to provide ACOs with claims data as part of two pilot programs under a $45 million State Innovation Model grant from the federal government.[36]

State and Non-State Use

To evaluate how Vermont state entities have used VHCURES, the SAO analyzed their use through the lens of the health care database statute.

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[35] U.S. Department of Health and Human Services, *Summary of Final Rule Provisions for Accountable Care Organizations under the Medicare Shared Savings Program,* 2014, 4. Read the Summary.

[36] See: The Health Care Innovation Project website.

18 V.S.A. §9410(a)(1) states that the GMCB "shall establish and maintain a unified health care database to enable the Commissioner (of Financial Regulation) and the Board to carry out their duties under this chapter … including:

A. Determining the capacity and distribution of existing resources;
B. Identifying health care needs and informing health care policy;
C. Evaluating the effectiveness of intervention programs on improving patient outcomes;
D. Comparing costs between various treatment settings and approaches;
E. Providing information to consumers and purchasers of health care; and
F. Improving the quality and affordability of patient health care and health care coverage."

Based on these six statutory duties, the Auditor's Office created the matrix on page 13 to organize the State's use of VHCURES. The matrix is arranged first by state entity and second by contractor, as state entities that use VHCURES rely heavily on contractors to analyze and work with the data.

As the matrix shows, Vermont has used VHCURES to fulfill all of the six statutory duties except for providing information to consumers and purchasers of health care. Many of the contracts used to create the matrix include services that are beyond the scope of working with VHCURES. This means that the maximum contract values in the matrix do not necessarily represent an accurate cost to the State of analyzing VHCURES.

Uses of VHCURES

State Entity			Statutory Duties Under 18 V.S.A. §9410 (a)(1)					
Contractor	**Term**	**Max Amount**	**A) Determining the capacity and distribution of resources**	**B) Identifying health care needs and informing health care policy**	**C) Evaluating intervention programs on patient outcomes**	**D) Comparing Costs between treatment settings and approaches**	**E) Providing info to health care consumers and purchasers**	**F) Improving quality and affordability of patient health care and coverage**
Green Mountain Care Board								
Truven Health Analytics, Inc.	4/9/2013 - 5/8/2015	$2,377,290	✓	✓		✓		✓
Wakely Consulting Group*	8/1/2012 - 7/31/2014	$400,000	✓	✓		✓		
University of Vermont	9/1/2013 - 8/31/2014	$179,000	✓	✓		✓		
Policy Integrity, LLC*	6/1/2012 - 5/31/2014	$156,000	✓	✓				
Vermont Association of Hospitals & Health Systems	7/1/2012 - 6/30/2014	$140,000	✓	✓		✓		
Pooled Clinical Data Partners, Inc. (Grantee)	1/1/2012 - 12/31/2012	$75,006	*Not enough information to support a determination.*					
VT Medical Society Education & Research Foundation	2/15/2013 - 12/31/2013	$14,500	✓	✓				
Department of BISHCA								
OnPoint Health Data	1/21/2011 - 12/31/2012	$904,150	✓	✓		✓		
OnPoint Health Data	1/26/2009 - 12/31/2010	$372,180	✓	✓		✓		
Policy Integrity, LLC	7/25/2011 - 12/31/2011	$90,000		✓				
Department of Vermot Health Access								
Wakely Consulting Group*	2/10/2012 - 4/30/2014	$6,122,624	✓	✓		✓		✓
OnPoint Health Data*	5/17/2011 - 12/31/2014	$2,362,764	✓	✓	✓	✓		✓
Burns & Associates, Inc.*	9/24/2010 - 6/30/2014	$1,530,610	✓	✓		✓		
Northeastern Vermont Regional Hospital*	1/24/2012 - 5/30/2014	$343,661	*Not enough information to support a determination.*					
Global Health Payment, LLC	12/15/2011 - 3/31/2012	$15,000	✓	✓				
Agency of Administration								
Umass Center for Health Law and Economics*	7/3/2012 - 3/31/2013	$175,000	✓	✓		✓		✓
Joint Fiscal Office								
Policy Integrity, LLC (four annual contracts)	7/1/2010 - 6/30/2014	$105,750	✓	✓		✓		✓

** = Amended Contract*

The check marks in the above matrix show the statutory duties that have been addressed by various contractors for the State. The GMCB and the Department of Vermont Health Access use VHCURES with a greater level of frequency and depth than do the other state entities authorized to use VHCURES. These contractors help the board and department carry out central regulatory functions such as evaluating DVHA's Blueprint for Health initiative. Contractor analyses are instrumental for the board's hospital budget, certificate of need, and insurance rate review processes. While VHCURES has not been widely used to evaluate how intervention programs affect patient outcomes, the Blueprint for Health initiative has worked closely with OnPoint to use VHCURES for this purpose. The Blueprint uses VHCURES to evaluate expenditures, utilization, and quality of care provided for its 100-plus participating practices.[37]

In addition to the State entities in the matrix, there are others that have used VHCURES with less frequency. For a list of state entities with data use agreements for VHCURES or that are planning to use VHCURES data, see the table on page 15, which outlines their specific uses. The table draws from contracts, data use agreements, state employee testimonies, and work products. Several of the key reports used to create the table were the Blueprint for Health 2013 Annual Report,[38] the Agency of Administration's 2013 study for a publicly financed health care system,[39] the Vermont Health Systems Payment Variation Report,[40] and the Joint Fiscal Office's 2013 Basic Needs Budgets and the Livable Wage.[41]

A wide range of non-state entities have also obtained data use agreements to access VHCURES. These entities range from universities to trade associations to non-profit policy institutes. For a list of non-state entities that once had or still have data use agreements, see the table on page 16. This table draws from data use agreements, work products submitted to the State, and a series of publicly accessible materials, including the Dartmouth Atlas,[42] the Dartmouth Atlas of Children's Health Care in Northern New England,[43] and William Hsiao's Act 128 Health System Reform Design.[44]

The tables on the following two pages are based on information from early 2014.

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37 To evaluate quality information, the Blueprint team uses performance measures by the National Committee for Quality Assurance, called the Healthcare Effectiveness Data and Information Set, or HEDIS. The Blueprint compares the frequency by which its participating practices employ HEDIS preventative measures, such as breast cancer screening, certain diabetes screening, and imaging studies for lower back pain.

38 Read: The Blueprint Annual Report.

39 Read: The Agency of Administration's 2013 study.

40 Read: The Vermont Health Systems Payment Variation Report.

41 Read: The Basic Needs Budgets and the Livable Wage report.

42 See: The Dartmouth Atlas.

43 See: The Dartmouth Atlas of Children's Health Care in Northern New England.

44 See: The Act 128 Report.

State Entity	VHCURES Use
Agency of Administration	AOA worked with the University of Massachusetts to analyze cost scenarios for a potential publicly financed health care system in 2017. Wakely, through its contract with DVHA, helped the AOA and UMass explore financing models.
Department of BISHCA	When BISHCA oversaw VHCURES and regulated health care finances, it contracted to OnPoint for a wide range of utilization and expenditure analyses. One of OnPoint's main reports was called an annual "report card." It compared utilization and expenditure data by demographic. This report card for policymakers differs from the department's hospital and health plan report cards, which were geared toward consumers and did not use VHCURES.
Department of Health	Department employees have used VHCURES in an attempt to validate data in the Uniform Hospital Discharge Data Set and to fill in gaps in the Birth Information Network. The department also used VHCURES to bill insurers for the cost of administering vaccines to their members under the immunization program.
Department of Mental Health	The department has used VHCURES in a limited capacity, analyzing data for a weekly brief on the treated prevalence of individuals with psychotic disorders.
Department of Financial Regulation	DFR has a data use agreement to use VHCURES for policy and Vermont Health Connect purposes, but had not begun using it in early 2014.
Department of Vermont Health Access	DVHA's Blueprint for Health initiative works with OnPoint's analytics team to evaluate expenditures, utilization, and quality of care for the 100-plus practices participating in the program. DVHA contracted to Burns and Associates to compare Medicare, Medicaid, and commercial insurance payments. Wakely provides a wide range of services to the department.
Green Mountain Care Board	GMCB works with three main contractors for analyzing VHCURES. Policy Integrity focuses on improving data quality, reviewing and conducting analyses, providing technical assistance to various state agencies, and developing a VHCURES training program. Truven, in its effort to find strategies that reduce the rate of health care cost growth, is beginning to help the board analyze VHCURES data from new perspectives and is standardizing the data to compare with federal numbers. Wakely, contracted to develop medical trend and forecasting models, has created a spreadsheet tool to help the board predict how variables would affect health care finance trends. The Vermont Association of Hospitals and Health Systems used VHCURES to develop the first phase of the board's payment variation report, which analyzes why hospitals are paid differently for the same procedures. The University of Vermont is currently working on the second phase of this study, which is aimed at identifying methods to reduce variation in payments to providers.
Health Care Reform Commission	The commission used VHCURES to develop a financial model for providers interested in Accountable Care Organizations.
Joint Fiscal Office	JFO works with Policy Integrity to use VHCURES to create its basic needs budgets, to evaluate cost-sharing subsidies for low-income health insurance programs related to Vermont Health Connect, and to evaluate various low-income health care programs. The office has also used VHCURES to assess administration models for a publicly financed health care system.
Tax Department	The department plans to use VHCURES to audit the new health care claims tax on insurers. It did not have an agreement to access VHCURES in early 2014.

Non-State Entity	VHCURES Use
University of Southern Maine Muskie School of Public Service	A Muskie research team gained access to VHCURES to analyze demand for health care services and the connection between out-of-pocket costs and health care utilization among low-income insurance beneficiaries. The researchers wanted to compare Vermont programs to those in Maine and Massachusetts.
University of Vermont	A UVM team sought to incorporate VHCURES data into a central database for clinical, research, administrative, and public health data.
America's Health Insurance Plans	The national trade association obtained a limited VHCURES data extract for a study aimed at identifying variation in health care costs and utilization rates among different groups of Vermonters, particularly those with chronic illnesses.
The Dartmouth Institute (Fisher)	Elliot Fisher, director of the Dartmouth Institute for Health Policy and Clinical Practice's Center for Population Health, led a research team that used VHCURES to track per-capita health care costs for Vermont's commercial insurance population. This research determined cost and resource distribution for the Dartmouth Atlas of Health Care.
The Dartmouth Institute (Goodman)	David Goodman, director of the Dartmouth Institute's Center for Health Policy Research, led a team that used VHCURES to study pediatric utilization and spending variation across Vermont, Maine, and New Hampshire. This work was used for the Dartmouth Atlas of Children's Health Care in Northern New England.
University of New Hampshire	The University of New Hampshire Institute for Health Policy and Practice signed an agreement with the State to research drivers of cost and quality in Vermont's health care system. That research has reportedly still not commenced.
Optum	The firm accessed VHCURES to develop a multi-payer claims database from different sources for the U.S. Department of Health and Human Services. GMCB's data manager reports that this effort was defunded.
The Health Care Cost Institute	The institute is integrating VHCURES data into its national database of commercial health insurance claims. Its researchers are supposed to provide the State with two reports comparing trends in Vermont with those of the rest of the country. Optum is a subcontractor for this work.
William Hsiao	Harvard's William Hsiao led a team that developed three new health care finance system proposals for the State of Vermont using data in part from VHCURES.

Management and Maintenance

The Auditor's office was unable to compile a complete record of all users who were sent VHCURES data because state records were incomplete. This is due in large part to the evolution of the authorization and data distribution processes in the first five years of the database. The State did not begin requiring each individual data user to sign documentation (affidavits) until 2011, and the State does not have a complete log of distributed data extracts. Additionally, some data originally sent to state data users were later given to other users – mainly state contractors – without a record kept by the State or OnPoint.

There is no single, central data hub by which users can access the data and the State can monitor its use. VHCURES data reside in numerous locations because extracts are distributed by the State's vendor to authorized users via hard drive. Data use agreements stipulate that data users must submit publications with information derived from VHCURES to the board and/or the Department of Vermont Health Access

15 days prior to release.[45] Aside from this requirement, there is no closed loop of communication back to the board that would inform the manager of the database how the data is used.

The board's present inability to monitor data utilization poses a risk of improper use of VHCURES. If antitrust concerns of collusion (outlined in "Objective 3: Consumer Information") pose a potential barrier to providing consumers with up-to-date price information, then these same concerns should apply when providing this data to parties that have self-interest in the medical and insurance sectors.

Although the data use agreements and applications are housed at the GMCB, many VHCURES records – such as contracts, work products, and other agreements – are scattered across state government. One key reason for the decentralization of VHCURES documentation is that the authority to manage the database shifted from BISHCA to DFR to the GMCB in a period of less than five years. Another key reason for this decentralization of information is that while the board is responsible for maintaining the database, a range of state entities use it.

The GMCB is statutorily responsible for maintaining the VHCURES database and ensuring that documentation and data use is compliant with state and federal regulations.

The board serves primarily in an administrative role managing the database and – just as the previous departments that oversaw the database – does not currently have staff proficient in working with VHCURES.

OnPoint Health Data is Vermont's vendor for creating and maintaining VHCURES. The firm collects, organizes, and inspects the quality of insurance claims data for VHCURES. OnPoint distributes quarterly extracts to authorized data users in the form of an encrypted hard drive. The most recent files of the complete database are more than 300 gigabytes in size and represent an update of all data that has changed in the last quarter. As old claims are adjusted, the new data files reflect these changes.[46]

In addition to the board, the Agency of Human Services (AHS) plays a data custodian role for state employees. The agency's central office houses a version of VHCURES on a server for state employees to work with.[47] The Department of Information and Innovation (DII) assists the agency in this role. DII and a contractor are also working with the GMCB to develop a Request for Proposal from vendors to manage the database after the current contract with OnPoint expires.[48]

Management Costs

Since 2008, the State has agreed to pay a maximum of $4,619,433 to OnPoint and the Maine Health Data Processing Center – which OnPoint was a part of – to develop and maintain the database. This covers three contracts, but does not include a maximum of $3,639,094 the State has agreed to pay OnPoint for analysis of VHCURES data, nor does it include the millions of dollars paid to other state

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45 Green Mountain Care Board, *Vermont Healthcare Claims Uniform Reporting and Evaluation System Data Use Agreement*, 2013.

46 Evidenced by data user demonstrations.

47 See: The AHS site.

48 Department of Information and Innovation and the Green Mountain Care Board, *Statement of Work for Project Manager to Oversee Next Phase of VHCURES*, 2013.

contractors to analyze this data (see the above subsection on "State and Non-State Use" and the table on page 13).

The State does not organize its accounting around VHCURES-specific costs, and the SAO was unable to determine the exact amount this program has cost taxpayers.

Presently, the board estimates that its Director of Analysis and Data Management spends 90 percent of her time administering VHCURES; the board's Data and Information Project Manager spends 50 percent of her time overseeing the VHCURES program; and the Director of Health System Finances spends 10 percent of his time on the project.[49] Applying these percentages to current salaries and benefits, we estimate that the GMCB will spend approximately $177,000 this fiscal year on in-house staff responsible for overseeing VHCURES.

This annual estimate is conservative. It does not factor in the time that other board employees spend on the project, such as the Executive Director, General Counsel, and the board itself. This estimate also excludes the time that employees from DVHA spend preparing and validating Medicaid data for the database. And it excludes the time that other state staff and contractors spend on developing VHCURES and maintaining its accessibility.

OBJECTIVE 2: PLANS FOR A NEW VHCURES

The GMCB is preparing to overhaul VHCURES. As part of this process, the board recently issued a Request for Proposal (RFP) to attract bids to build and maintain the new database, as the State's current contract with OnPoint is set to expire at the end of August 2014.

To identify what plans are in place for a new version of the database, the SAO referenced two main documents: 1) the GMCB Statement of Work to obtain a project manager for the transition;[50] and 2) an outline of proposed changes to the VHCURES program.[51]

The main goal is to better track individual patients as they move through Vermont's health care system, while securing personal identifiers. A major component of this aim is to reduce duplication of individual patients in the dataset.

The plan is for one lockbox vendor to receive data with personal identifiers, such as names, social security numbers, street addresses, and medical record numbers. The contractor would secure the information, encrypt it, and transfer it to a second vendor that would receive and organize the de-identified information in a data warehouse. This level of identification differs from the current model, where commercial insurers provide de-identified data to the vendor.

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[49] Estimates provided by GMCB General Counsel.

[50] Department of Information and Innovation, *Statement of Work*, 2013.

[51] Green Mountain Care Board, *VHCURES Program Changes under Consideration: Stakeholder Meeting*, 2013. See the VHCURES Program Changes under Consideration.

The board's seven goals for this new version of VHCURES are to:

1. Improve identity management for health care providers and patients;
2. Develop a data model that is less focused around a single claim, is centered on clinical events, and includes additional financial information;
3. Eliminate multiple versions of the database that are a result of the current decentralized data distribution system;
4. Improve data consistency and security;
5. Automate and streamline data uptake and quality control;
6. Develop a strong analytics mechanism for accessing the data; and
7. Integrate other data sources from inside and outside of state government.

The board is considering a VHCURES governance structure based on CMS guidelines for dealing with Medicare data. The board is also looking into the inclusion of new data for categorizing race and ethnicities, product information, and different code and payment types.

The board's annual report also indicates that it plans to address the remaining statutory duty of providing information to consumers of health care. In Appendix B, the board wrote, "In 2014, we will explore the feasibility of using VHCURES … as a means to provide cost information to Vermonters."[52] The current regulatory documents for accessing VHCURES – data use agreements and affidavits – explicitly prohibit making public the rates that insurers and providers negotiate.

Over the next several years, one of the main subjects of analysis and debate about Vermont's health care future will be over a proposal to implement a publicly financed, universal health care system, called Green Mountain Care.[53] Regardless of whether the State implements a publicly financed system, the importance of providing Vermont patients with this information would not be diminished. Moving to such a system may reduce many of the difficulties associated with implementing an accurate price and quality information system. Using VHCURES to fulfill the statutory charges of providing information to consumers and establishing an empowering price and quality information system are important so long as Vermont patients pay different providers different rates for the same services and receive care that varies in quality.

OBJECTIVE 3: CONSUMER INFORMATION

What providers charge and what insured patients and their insurers pay for medical services often bear little resemblance to each other. The amount that an insured patient actually pays for a service will vary based on the rate that an insurer negotiates with a specific provider – not the provider's charge.[54] Although some federal and state price transparency initiatives have made charge data available to patients, this information is of little use to those consumers with insurance.

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52 Green MountainCare Board, *Annual Report to the General Assembly*, 2014, 34. Read the Annual Report.

53 Act 48, 2011.

54 Gerard F. Anderson, "From 'Soak The Rich' To 'Soak The Poor': Recent Trends In Hospital Pricing," *Health Affairs*, 26, no.3 (2007): 780-789. Read the article.

The price information that is most pertinent to thousands of Vermonters is the insurer-provider negotiated rate and the portion of the rate that a patient is liable for. While provider institutions and insurers are acutely aware of these negotiated rates for business purposes, patients don't typically know the cost of care until after receiving it. VHCURES is used to inform policymakers of cost trends based on these negotiated rates, but it hasn't yet been used to inform patients, who could use such data to potentially save on health care expenses.

Vermont also does not host a central site for uninsured Vermonters to compare prices. Health care prices for the uninsured are often based on charges that are significantly higher than the payment rates that providers negotiate with insurers. Numerous providers do, however, offer uninsured Vermonters discounts and financial assistance, which can drastically reduce health care expenses.[55]

The third objective of the SAO's inquiry into VHCURES is to assess how the database could be used to provide greater transparency of health care costs and to better inform consumers of the price of specific medical procedures. To meet this objective, the Auditor's Office analyzed:

1. Vermont's current health care transparency system;
2. Numerous public and private transparency initiatives; and
3. Feasibility.

Vermont's Health Care Information System

Vermont's current health care price and quality transparency system offers patients limited information for making health care decisions. Although the underlying legal structure exists to provide pertinent information, the State has not yet implemented an effective program to help Vermont patients easily compare price and quality information in advance of care, based on their unique situations.

The health care database statute, 18 V.S.A. § 9410(2), outlines the State's charge to create and maintain a consumer information system:

> (A) The program authorized by this section shall include a consumer health care price and quality information system designed to make available to consumers transparent health care price information, quality information, and such other information as the Board determines is necessary to empower individuals, including uninsured individuals, to make economically sound and medically appropriate decisions.
>
> (B) The Commissioner may require a health insurer covering at least five percent of the lives covered in the insured market in this State to file with the Commissioner a consumer health care price and quality information plan in accordance with rules adopted by the Commissioner.
>
> (C) The Board shall adopt such rules as are necessary to carry out the purposes of this subdivision. The Board's rules may permit the gradual implementation of the consumer health care price and quality information system over time, beginning with health care

[55] For examples, see the hospitals' programs. The Vermont Coalition of Clinics for the Uninsured also helps low-income uninsured and underinsured Vermonters obtain care.

> price and quality information that the Board determines is most needed by consumers or that can be most practically provided to the consumer in an understandable manner. The rules shall permit health insurers to use security measures designed to allow subscribers access to price and other information without disclosing trade secrets to individuals and entities who are not subscribers. The rules shall avoid unnecessary duplication of efforts relating to price and quality reporting by health insurers, health care providers, health care facilities, and others, including activities undertaken by hospitals pursuant to their community report obligations under section 9405b of this title.

When the legislature initially called for a price and quality information system, the charge fell to BISHCA. On Oct. 1, 2008, BISHCA Rule H-2007-05 took effect, placing the onus on insurers and providers to apprise consumers of price and quality information. The rule called for a four-phase rollout of the insurers' system that ramped up the quantity of information from late 2008 to early 2013.

The rule requires insurers covering more than five percent of Vermont lives to provide their members with a range of price and quality information concerning inpatient and outpatient procedures, prescription drugs, and medical supplies. The rule specifically says: 1) "The health insurer shall permit members to compare prices and median prices among specific hospitals, physicians, pharmacies and other entities," and 2) "Price information shall be updated at least annually, and when hospital, physician, pharmaceutical, or other seller contracts are issued or reissued."

To enforce the rule, DFR requires health insurers covering more than five percent of the population to submit consumer information plans. After reviewing the plans, which the department treats as confidential,[56] the SAO found that insurers created plans that appeared to put them in compliance with the rule. The plans showed that the insurers created systems with varying degrees of functionality. The level of price and quality detail, and the ability to compare these elements between providers, varies by insurer system.

A test of one insurer system, which SAO staff had access to as members, found that the level of price information varied significantly depending on the plan that a member was enrolled in, and the system did not tell the consumer what a service would cost him or her specifically. Additionally, the system provided very little quality information, which was only available for three of 25 physicians tested at random.

The statute and the department's rule also call for an information system for uninsured consumers. The rule places the responsibility on hospitals and health care practices to provide price and quality information and submit uninsured consumer information plans. Providers are supposed to supply uninsured patients with information about free care, discount policies, eligibility for public insurance programs, and a tool for patients to estimate the cost for an in-patient, out-patient, or diagnostic procedure.

DFR provided the SAO with evaluations of 14 provider plans and correspondence between the State and those providers. The department's counsel indicated that Uninsured Consumer Information Plans were

[56] DFR cited 1 V.S.A. §317 and 8 V.S.A. §22 as statutory impetus for keeping insurer consumer information plans and affiliated materials confidential.

sent to the State archives, but the plans have not been located. DFR evaluated the plans once in 2009 and has not revisited them since. The department does, however, link to hospital discount and free care policies on its website.[57]

In addition to this rule, the department has published hospital and health plan report cards.[58] While these report cards display some quality information, they do not show price information that would be pertinent to many health care consumers. The price information is based on charges, not payment rates, and it is not presented in a way that could help most consumers discern their cost of care.[59]

Although the present statute splits responsibility for implementing a consumer information system between DFR and the GMCB, DFR still takes responsibility for enforcing BISHCA Rule H-2007-05. The department does not, however, see it as a responsibility to inform consumers of the information systems that the rule calls for, and it has done little in this regard.

"There is no obligation that the Department inform consumers about this access to information," the department's counsel wrote. "However, the Department has informed consumers about access to information under the statute and rule by posting the rule on the Department's website."[60]

DFR is attracting a very low percentage of Vermont residents to its consumer websites. In 2013, the front page of the hospital report card site attracted fewer than 700 visitors. Its health plan report card site and the site that links to hospital assistance information attracted fewer than 100 visitors each.

Meanwhile, GMCB personnel say they don't presently have adequate resources to implement and enforce the information system called for in statute.[61] The board does, however, appear to find such information to be important to Vermont consumers, as its annual report states, "Vermonters should be aware of the costs of the health services they receive. Costs should be transparent and easy to understand."[62]

Public and Private Transparency Initiatives

U.S. health care consumers have become increasingly responsible for paying a larger share of the country's growing health care costs,[63] and the trend holds true in Vermont. The percentage of insured U.S. workers enrolled in high-deductible[64] health plans – which can be paired with savings accounts –

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57 See: The DFR website guide to Vermont's community hospitals.

58 See: The DFR health care report cards.

59 See: An example of inpatient charges.

60 Written testimony by DFR counsel.

61 Written testimony by GMCB counsel.

62 GMCB, *Annual Report,* 2014, 34.

63 U.S. Government Accountability Office, *Health Care Price Transparency: Meaningful Price Information is Difficult for Consumer to Obtain Prior to Receiving Care*, 2011. Read the report.

64 The definition of a high-deductible plan varies from year to year. For calendar year 2014, the U.S. Internal Revenue Service Definition for a high-deductible plan is that with an annual deductible no less than $1,250 for an individual and no less than $2,500 for a family. See the IRS publication.

has increased over the past seven years, from an estimated 4 percent in 2006 to 20 percent in 2012.[65] Meanwhile, Vermont enrollment in high-deductible plans grew to 34 percent of the commercial market, from 39,070 lives in 2009 to 61,499 lives in 2012.[66]

The federal Affordable Care Act now mandates that Vermonters have health insurance, and Vermont's commercial market pairs the most affordable health insurance premiums with the highest deductibles, stretching into the thousands of dollars. Families who buy plans on Vermont Health Connect, the State's new health insurance exchange, could find themselves paying as much as $12,700 annually for medical care on top of premiums.

Vermonters are given a greater incentive to make decisions based on the cost of care, but they are not given the tools to effectively weigh their options. Vermonters could use transparent price and quality information to identify higher value opportunities.

As the Princeton economist Uwe Reinhardt explained:

> The central idea of consumer-directed care is that the high degree of cost sharing will force patients to take a more active interest than they hitherto have had in the cost-effectiveness of their care. **This "consumer empowerment," as it is sometimes called, can only occur, however, if prospective patients actually have easy access to user-friendly, reliable information** on at least three dimensions of their care: the prices charged by competing providers of health care; the costliness of practice styles adopted by these various providers — that is, the prices times the quantities of services and supplies they package into the treatments they render; and the quality of these providers' services.[67]

In recent years, numerous consumer price transparency tools have cropped up across the country; some insurers have begun crafting incentives around these tools and higher deductibles; and the body of research on health care transparency has grown.

New Hampshire's HealthCost

In 2007, the New Hampshire Insurance Department launched a web-based price comparison tool called HealthCost. The tool, located at nhhealthcost.org, drew from the State's all-payer claims database to provide consumers with price estimates for about 30 common health care services.

What distinguished New Hampshire's price transparency effort from that of many other states is it allowed consumers and providers to easily query prices that were based on insurer-provider contracts, or the amounts patients and commercial insurers actually pay for services and products. The tool also bundled payments around a specific service to estimate the cost of care. Many other such tools were

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65 The Kaiser Family Foundation and the Health Research and Education Trust, *Employer Health Benefits Annual Survey*, 2013, 144-149. See the survey.

66 Vermont Department of Financial Regulation Insurance Division, *The Commercial Health Insurance Market in Vermont*, 2013, 8-11. See the report.

67 Uwe Reinhardt, "The Pricing of U.S. Hospital Services: Chaos Behind a Veil of Secrecy," *Health Affairs,* 25, no. 1, 2006, 57-69. Read the article.

and still are based on provider charges, which don't factor in the discounts and negotiated rates that insurers and providers broker.[68]

HealthCost estimated rates by determining the median amount that an insurer paid to a specific provider, under one of that insurer's policies, for a specific service over a 15-month period. New Hampshire removed the top five percent and bottom one percent of all payments in the sample to eliminate outliers. The median was then increased by five percent to account for rate inflation, as the data came from a sample that stretched back 21 months and ended six months before an update to the site.[69] HealthCost rated the variability of the data sample and the complexity of patient cases that were part of the sample.

The tool not only showed the estimated rate for a particular provider and service, it showed the pertinent cost to a consumer based on the consumer's deductible and coinsurance levels. A consumer began the HealthCost process by choosing a procedure, a zip code, and the mileage radius he or she was willing to travel for that service. The consumer then entered his or her insurance carrier, plan type, and liability levels. The tool provided the consumer side-by-side rate estimates based on the consumer's insurance plan and rates that the insurer negotiated with providers in the specified mileage radius.

In addition to commercial insurance prices, HealthCost also provided information to uninsured consumers based on hospital charges, minus any discounts hospitals provided the uninsured.

New Hampshire shifted to a new managing vendor for its all-payer claims database in the summer of 2012.[70] Due to difficulties with this transition, accurate, up-to-date claims data became unavailable, and the New Hampshire Insurance Department decided to temporarily take HealthCost offline in 2014.[71]

As part of this vendor transition, New Hampshire is overhauling the HealthCost site. The state is paying the University of New Hampshire almost $95,000 to create the new version of the tool.[72]

HealthCost Results

Researchers at the former Center for Studying Health System Change (HSC), which recently merged with Mathematica Policy Research, have conducted two analyses of NHHealthcost. An early study found that the price transparency initiative had little effect on the market, but a study published this year indicates that the market has responded.

In 2009, two years after HealthCost opened, HSC teamed up with the New Hampshire Insurance Department to evaluate the website's impact on health costs. The quantitative analysis part of the study found that one year after launching HealthCost, price variation between providers had not decreased

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68 Ha T. Tu and Johanna R. Lauer, "The Impact of Health Care Price Transparency on Price Variation: The New Hampshire Experience," *The Center for Studying Health System Change Issue Brief*, no. 128 (2009).

69 Evidenced by the methodology section of the former nhhealthcost.org site and the health policy analyst who has overseen the program at the New Hampshire Insurance Department.

70 State of New Hampshire, Contract with Milliman, Inc., 2012.

71 Evidenced by interviews with New Hampshire officials.

72 Contract documents provided by the New Hampshire Insurance Department show that the state is paying $62,725 University of New Hampshire for SAS programming and another $31,569 to the university for the website's new content management system and affiliated data work.

for services showcased on the site. While there are numerous factors that drive price variation, one reason HSC identified for HealthCost's lack of short-term impact on price variation is that the New Hampshire market, much like Vermont, features weak provider competition.[73]

At the time, very few New Hampshire residents directly felt the effects of rate variation. Only 5.3 percent of New Hampshire's commercial market was enrolled in high-deductible plans, providing residents little incentive to compare prices. Additionally, HSC found that the site had a limited impact on hospital-insurer negotiations in its first two years.

HSC revisited HealthCost in 2013. The new study found that while HealthCost and subsequent public price transparency initiatives did not stimulate a noticeable upswing in consumer price shopping, they appeared to influence New Hampshire's health care market.

"The research found a wide belief within the state's health care and policy communities that HealthCost was important in highlighting wide gaps in provider prices – particularly between hospital outpatient departments and free-standing facilities, but also among different hospitals," the authors wrote.[74]

Many respondents to the 2013 study found that the public's heightened awareness of price variation led to two key developments: 1) a restructuring of hospital-insurer negotiations, and 2) a shift to new insurance designs that encouraged patients to choose lower cost services. Many respondents viewed public price transparency initiatives as a facilitator of these new benefit structures, and these plan designs, in turn, strengthened the usefulness of price transparency tools. Subsequently, private insurers created price tools to encourage shopping for providers.

The rebalancing of provider-insurer negotiations was evidenced chiefly by a public dispute between the state's largest insurer, Anthem Blue Cross Blue Shield, and New Hampshire's most expensive hospital, Exeter Hospital. HealthCost put a public spotlight on Exeter's higher prices and at least one newspaper used the tool as evidence of the hospital's high rates. The reported result was that Anthem was able to negotiate a deal with Exeter that actually cut rates. These negotiations, HSC found, had a ripple effect across the market.

Anthem and Harvard Pilgrim Health Care – the insurer that holds the second largest share of the New Hampshire commercial market – have introduced web-based, price-comparison tools that inform consumers of the amounts they are likely to pay for services. This information is more valuable now than it was when HSC conducted its initial study, as New Hampshire's enrollment in high-deductible health plans grew from 5.3 percent of the commercial market in 2007 to 18 percent in 2011.

Anthem's price comparison tool, called SmartShopper, is provided by the third-party firm Compass Healthcare Advisers. Anthem uses SmartShopper in conjunction with financial rewards to promote consumer price-shopping. The company has created copayment tiers for many products to encourage its members to choose providers that offer less expensive services, and members who elect to use a low-priced provider that is recommended by SmartShopper receive a reward of about $100.

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[73] Ha T. Tu, "The Impact of Health Care Price Transparency on Price Variation," 2009, 2-3.

[74] Ha T. Tu and Rebecca Gourevitch, *Moving Markets: Lessons from New Hampshire's Health Care Price Transparency Experiment,* 2014, 3. Read the report.

"When patients use independent labs, they incur no out-of-pocket costs, and when they use freestanding ambulatory surgery centers (ASCs), they are subject only to copayments ranging from $75 to $100, depending on the service," the HSC authors wrote. "In contrast, those who choose a facility designated as a hospital outpatient department are subject to their policy's full deductible and copayment or coinsurance requirements. For the subset of consumers enrolled in HDHPs, the cost-sharing differential between hospital-based facilities under the tiered-copayment benefit is especially stark."[75]

It is unclear if this system is replicable in Vermont due to the current lack of these alternative providers, though Anthem recently designated two hospitals in the more-remote region of northern New Hampshire as low-priced providers. While this plan design used by Anthem and Harvard Pilgrim can encourage lower cost behavior, residents living in more rural regions, like many areas of Vermont, will have fewer options.

Additional State and Private Sector Consumer Tools

Two other neighboring states have developed consumer tools in recent years that provide payment estimates using claims data. The Maine Health Data Organization followed New Hampshire's lead by creating Maine HealthCost.[76] The site functions similarly to New Hampshire's, drawing payment estimates from insurance, service, and geographical inputs. The Maine site derives cost estimates for services based on median payment amounts for a given sample year, 2010 to 2012. The Maine model also accounts for the complexity of patient cases and the precision of an estimate.

One key difference between the two comparison tools is that Maine's model shows both the overall payments and a breakout, which is split into professional and facility charges.[77]

The Massachusetts Health Care Quality and Cost Council created a similar web-based tool, called My Health Care Options, which draws from claims and other data sources.[78] The tool allows consumers to compare prices for up to four providers for specific services. The site shows the median payment to a provider from a one-year sample. It also shows a high cost point at the sample's 85th percentile and a low cost at the 15th percentile. Furthermore, the site shows whether a provider delivers a service at a price above, below, or in line with the state median.[79]

One key distinction between the Massachusetts site and those of Maine and New Hampshire is that it provides some quality information for certain providers and services. Additionally, the Massachusetts site does not provide price estimates based on a specific insurance plan, and the data used is often four to six years old.

Insurers and other private entities have created consumer information tools. In addition to Anthem, other insurers across the U.S. – such as Aetna[80] and United Health Care[81] – have developed price

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75 Ibid, 5.
76 See: The Maine HealthCost website.
77 See: The Maine HealthCost methodology.
78 See: Massachusetts' My Health Care Options.
79 See: The Massachusetts methodology.
80 See: The Aetna tool website.

comparison tools for their members. An advantage of this model for insured consumers is that an insurance company can provide up-to-date price information tailored to an individual's specific plan. Third-party solutions have also appeared from businesses such as Castlelight Health[82] and Change Healthcare.[83] In contrast to these other models for members and customers, a Minnesota non-profit, called the MN Community Measurement, created a similar tool to that of Massachusetts.[84]

Vermont Physicians

Physicians are calling for greater price and quality transparency in Vermont's health care system. A 2013 GMCB and Vermont Medical Society Education Research Foundation report states: "An oft repeated request was for information about the cost of the care they were prescribing for their patients. Practitioners would like to have access to the cost of diagnostic testing, procedures, and drug pricing at the various facilities serving their patients so they could direct them to the least costly option. … Primary care physicians would like to direct patients to facilities that are less expensive or that offer higher quality care; particularly for high volume, high cost preference sensitive procedures like knee and hip replacements or elective advanced imaging like CT scans and MRIs."[85]

In a separate study by the two organizations, hospital physicians made clear the desire to compare price and quality metrics. The report states: "Nearly every physician mentioned interest in being able to compare their own performance and that of their institution to other institutions in the region. There were many comments about the lack of performance benchmarks at any level of aggregation. Specifically, there were many requests for information on clinical and financial effectiveness and efficiency such as clinical process and outcomes measurements, overall utilization of services, utilization of services per admission, overall costs and cost per admission."[86]

Three Key Points

In recent years, a range of public and private research initiatives have delved into the subjects of health care transparency and high-deductible health plans. Emerging from the SAO's literature review are three key concepts for Vermont policymakers and administrators to keep in mind when approaching health care price transparency.

Price information is more helpful when paired with quality information.

Numerous studies have shown that price and quality are not synonymous in health care.[87] A recent experiment that drew from 1,421 employees found that many subjects conflated price with quality, and price information alone can be confusing. The research team found "that presenting cost data

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81 See: The UnitedHealthcare website.

82 See: The Castlelight Health website.

83 See: The Change Healthcare website.

84 See: Minnesota HealthScores.

85 Green Mountain Care Board and Vermont Medical Society Education and Research Foundation, *Recommendations for Optimizing Rural Care in Vermont*, 2013, 38. Read the Report.

86 Green Mountain Care Board and Vermont Medical Society Education and Research Foundation, *Physician Opinion on Optimizing Hospital Based Care in the Vermont Region,* 2013, 38. Read the Report.

87 Read: "Understanding Differences Between High- And Low-Price Hospitals: Implications for Efforts to Rein in Costs," *Health Affairs*. And, "In Health Care, Cost Isn't Proof of High Quality," *New York Times*.

alongside easy-to-interpret quality information and highlighting high-value options improved the likelihood that consumers would choose those options."[88]

Patients appear to care more about health care prices when they share more of the cost.
An analysis by the Rand Corporation found that increased cost sharing results in decreased health care spending, and consumers with higher deductibles use less health care.[89] These phenomena could be the result of healthy, consumer-conscious decision-making, or they could be caused by people foregoing health care because they don't have the money to pay for it.

Consumer information is most useful for care that is non-urgent and predictable.
While patients may know ahead of time that they need certain forms of care, there are many instances where a health care problem suddenly arises. Price and quality information is not as useful for people who need urgent care because they don't have time to weigh these factors.[90]

Feasibility

The Vermont SAO found strong evidence to suggest it is feasible for the State – or possibly another third party – to use VHCURES to provide consumers with greater price transparency. There also exist opportunities for the State to pair this information with quality measures, to work closer with commercial insurers to provide patient-specific price information, and to better inform Vermont's uninsured population.

The SAO investigated the underlying technical and legal structures of a consumer information system. The SAO did not attempt to design such a system.

Technical Feasibility

Neighboring states have shown that price information can be made more transparent using an all-payer claims database, and GMCB contractor, Policy Integrity, ran two analyses for the SAO that demonstrate payment rates can be pulled from VHCURES and organized in a comparative package.[91]

The SAO and Policy Integrity collaborated to test whether VHCURES could be used to: 1) compare the amounts one commercial insurer pays different providers for the same service, 2) compare the amounts different insurers pay one provider for the same service, and 3) isolate median payment amounts for comparative purposes. Organizing this payment information in a comparative format is crucial to establishing the underlying structure of a consumer price tool because insured consumer costs are rooted in these payment rates (and their deductibles, out-of-pocket maximums, and coinsurance levels).

The first analysis compared payment rates for one type of high-volume office visit. The analysis showed the payment rate distribution for two insurers and two providers across their insurance products, such

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88 Judith H. Hibbard, Jessica Greene, Shoshanna Sofaer, Kirsten Firminger, and Judith Hirsh, "An Experiment Shows That a Well-Designed Report on Costs and Quality Can Help Consumers Choose High-Value Health Care," *Health Affairs*, 31, no.3 (2012), 560-568. Read the article.

89 Rand Corporation, *Analysis of High Deductible Health Plans,* 2009. Read the analysis.

90 GAO, *Health Care Price Transparency*, 2011.

91 Public disclosure of this content is prohibited by the GMCB data use agreement and affidavits.

as preferred provider organization plans and point of service plans. This brief analysis of November 2011 data demonstrated that VHCURES could be used to compare the payment rates of different insurance products for the same service with different providers. This information could help consumers more accurately identify higher and lower cost providers if the sample were more recent, drew from a longer period of time, and were paired with a consumer's liability levels, like New Hampshire's HealthCost did.

The second analysis showed the distribution of rates for lower extremity joint replacements. Much like the first analysis, this one showed what different commercial insurers pay different providers for the same procedure. The identifying diagnostic code in the database, however, includes a range of procedures, and the payment rates varied significantly.

A comparison of the two analyses shows that more-involved, inpatient procedures can have a much wider range of variation and statistical complexity than do the typical office visit.[92] This level of variation for more involved procedures is a hurdle to providing consumers with easy-to-understand price information.

In addition to Policy Integrity's work, the insurer consumer information plans submitted to DFR, in accordance with BISHCA Rule H-2007-05, show that Vermont's commercial insurers are able to provide price information with varying degrees of utility. A test of one insurer's system showed that one plan's median payment rates were available for 22 physicians in a 25-physician sample. In this case, if a consumer's deductibles and coinsurance levels were applied to these payments, a patient would have a much clearer idea of what a specific service from a specific physician would cost him or her. State entities could work with commercial insurers to provide consumers with consistent, plan-specific price information.

VHCURES also contains provider charges. If charge rates were paired with provider assistance information for the uninsured, this could help uninsured patients more easily shop for care.

Lastly, there are opportunities to pair price information with quality information. CMS provides overall quality metrics for hospitals – but not for specific physicians – on its Medicare website.[93] DFR and the Vermont Program for Quality in Health Care compare quality information on the department's hospital report card website.[94] The Blueprint for Health uses VHCURES data to provide its participating physicians with quality metrics, which put a physician's metrics into a comparative context across state and hospital service areas. While this Blueprint information is not public at present, similar methods could be used to create a physician quality information system in the future. Such information would need to be vetted by an independent entity to ensure its accuracy.

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92 The SAO drew from Current Procedural Terminology (CPT) code 99213 for the office visit and Diagnostic Related Group (DRG) number 470 for the lower joint replacement.

93 See: Medicare Hospital Compare.

94 See: DFR's Hospital Report Card.

Legal Feasibility

The SAO collaborated with the Office of the Attorney General of Vermont to analyze antitrust concerns associated with making provider price information accessible to consumers.[95]

"In general, the sharing of providers' pricing information raises two kinds of antitrust concerns: first, that the availability of one another's pricing information could lead competitors to engage in price-fixing; and second, that the availability of such information may stabilize prices and facilitate coordinated behavior," wrote an Assistant Attorney General.

To explore these concerns, the SAO proposed two price transparency models for disclosing prices negotiated between providers and commercial insurers. The first proposed model, which drew from New Hampshire's HealthCost, is a tool run by a third party that would provide a consumer with a median price range for a specific service, at specific providers, based on a consumer's insurance plan. The 12-month sample used to establish a median range would be roughly six months old.

This model appears to clearly meet two of three conditions in the so-called antitrust "safety zone," outlined in the Department of Justice (DOJ) and Federal Trade Commission's (FTC) joint Statements of Antitrust Enforcement Policy in Health Care.[96] Those three conditions are:

1. The collection of data is managed by a third party, such as a government agency, consultant, academic institution, or trade association;
2. Information that is available to competing providers must be older than three months; and
3. For each statistic there must be at least five providers and no provider's data can account for greater than 25 percent of the statistic on a weighted basis.

The third condition would not automatically be met because Fletcher Allen Health Care and Dartmouth-Hitchcock Medical Center account for a large number of claims in the database. The State or another third party would need to test this condition for the different statistical samples used to create a consumer tool.

"The strength of the facts on the first two factors might provide some breathing room on the third, but that is unpredictable at this time," wrote the Assistant Attorney General.

The SAO's second proposed model for legal consideration would avoid antitrust issues by extending BISHCA Rule H-2007-05 and placing the responsibility of creating a more robust price and quality information system on commercial insurers. This model is not altogether different from the rule that already exists, but it would require all insurers covering more than five percent of Vermont's insured lives to create a tool that would allow consumers to compare price information, which could be tailored to their liability levels. An added benefit of this model is that insurers could provide more up-to-date price information that is customized to a patient's specific insurance plan and situation. Although this model does not present anti-trust issues, the Attorney General's Office noted that "contract issues should be vetted."

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95 See Appendix A for the Memorandum from the Attorney General's Office.

96 See: DOJ and FTC Antitrust Enforcement Policy in Health Care Statement 5 – Providers' Collective Provision of Fee-Related Information to Purchasers of Health Care Services.

These models do not address uninsured consumer information because the identified legal concerns surrounding price transparency pertain chiefly to rates negotiated between commercial insurers and providers. While the first model would lay the groundwork for a system that could be extended to provide uninsured consumers with comparative price and quality information, the second model would not.

Since the DOJ and FTC issued their antitrust statements for health care in the mid-1990s, federal legislation has enabled the creation of provider organizations, called Accountable Care Organizations (ACOs). The aim of the CMS Medicare Shared Savings Program, which Vermont's ACOs fall under, is to encourage providers within an ACO to work collaboratively to deliver care for a Medicare population at a lower cost, while improving quality. In late 2011, the DOJ and FTC issued a "Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program."[97]

As part of this program, participating ACO providers have access to their patient's Medicare claims data for the first time.[98] The State of Vermont is expanding this program via a federal State Innovation Model grant so that ACOs can test this model with Medicaid and commercial insurers. As part of Vermont's pilot ACO programs, DVHA will provide Medicaid claims data to two ACOs using the same data format it sends to OnPoint for VHCURES.[99] Blue Cross Blue Shield of Vermont and MVP HealthCare are set to provide ACOs with similar data.[100]

DATA VALIDITY

Validating the data in VHCURES fell outside the scope of the SAO's inquiry, but the SAO acknowledges that the quality of VHCURES data is fundamental to the state's ability to use it for policy and consumer information purposes.

A study commissioned by the GMCB and the Vermont Radiological Society tested the validity of VHCURES data for cranial CT scans by comparing that data with data from Porter Medical Center and Fletcher Allen Health Care. The Porter sample was small enough that the researchers could perform a claim-by-claim analysis. It found that all of the commercial claims in VHCURES could be matched to the provider's claims, but the provider record contained additional claims that weren't in VHCURES. Ultimately, the researchers found that 79 percent of Medicaid submissions matched and 64 percent of commercial billings matched Porter records. Fletcher Allen's records included far more claims. Therefore the researchers used a statistical approach to analyze them and found similar matching rates to Porter.

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97 Federal Trade Commission and Department of Justice, *Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program,* 2011. See the Statement.

98 U.S. Department of Health and Human Services, *Summary of Final Rule Provisions for Accountable Care Organizations under the Medicare Shared Savings Program,* 2014, 4. Read the Summary.

99 Department of Vermont Health Access Contracts with OneCare Vermont Accountable Care Organization, LLC, and Community Health Accountable Care, LLC, 2014. See the OneCare Contract and the Community Health Contract.

100 Green Mountain Care Board, *Draft Vermont Commercial ACO Pilot Data Use Standards*, 2014.

One of the key reasons the researchers cited for the lower commercial matching rates was the difference in how providers and VHCURES code for payers. Ultimately, the researchers concluded that "the state's VHCURES database is sufficiently robust to support the use of the VHCURES data set to analyze statewide and inter community variation of the use of advanced imaging."[101]

OnPoint tests insurer data for completeness, per-member-per-month payments, and irregular trends.[102] But some researchers have encountered problems with the data. Global Health Payment, in trying to reconcile VHCURES data for a GMCB project, reported difficulty with matching data for one commercial insurer, while being able to validate data for Medicaid and another commercial payer.[103]

The Vermont Association of Hospitals and Health Systems included a key finding about VHCURES data quality in its payment variation report for the board. The association recommended that the state undertake a comprehensive data review.

The GMCB notes that the Health Care Cost Institute and Truven have been able to use the data to support a range of analyses, and the board plans to address weaknesses in the dataset when it begins overhauling VHCURES this year.

[101] Vermont Radiological Society, *Optimizing the Use of Advanced Imaging in Vermont*, 2013.
[102] Evidenced by a series of validation test documents provided by OnPoint and the GMCB.
[103] Evidenced by documentation provided by GMCB Director of Payment Reform.

MEMORANDUM

To: Douglas R. Hoffer,
Vermont State Auditor

From: Jill S. Abrams, Assistant Attorney General

Re: Proposed Health Care Transparency Models

Date: March 25, 2014

I. Overview

You have asked me to review two potential health care transparency models being considered by the State Auditor's Office, and to identify any associated antitrust concerns. This memo is provided to assist in the consideration of the issues, but is not intended as advice to any specific state agency. Based on the factual information you provided to me and my own research, Model 2 does not appear to present an antitrust barrier. Model 1 raises an antitrust question which is addressed below. Antitrust law is particularly fact sensitive and changes to the models may affect the legal analysis reflected below.

II. Relevant Facts

A. Model 1

Model 1(which is fashioned primarily on models currently in place in New Hampshire and Maine) uses queries of VHCURES, the State's all-payer claims database, to provide price information to Vermont consumers. Under Model 1, a Vermont consumer would be able to compare the median price range (40-60%) for 30 to 60 medical procedures and services[1] rendered by providers around the state, under the consumer's insurance coverage.

Here is an example: A consumer covered by a Blue Cross POS plan needs a colonoscopy. She enters a query which includes her insurance carrier, plan type and liability levels, i.e., annual deductible and co-insurance, and zip code and mileage radius to define the geographical radius for provider results. The computer program searches VHCURES data for all of the colonoscopies performed over a 12 to 15 month period (so if she entered the query now, the program would look at

[1] The tool would also provide median prices for prescription drugs based on specific dosages.

2013 data) for each provider in the specified geographic area. It generates a median price estimate for the total combined amount paid to the provider by both the consumer and the insurer. This is a negotiated amount. The consumer would also receive an estimate of the amount for which the consumer would be personally liable, based on the consumer's specific information (annual deductible, co-insurance, etc.) and the median estimated rate. The consumer could perform the search for any number of specific providers and compare the median cost to her for care at those providers versus the state median price for that procedure.

B. Model 2

Under Model 2, insurers would be required to create an online consumer tool that would enable their members to compare health care costs based on actual negotiated rates their insurers pay to providers. Health insurers would be required to provide median price estimates (40-60%) for all procedures, services, prescriptions, and equipment identified in BISHCA's Health Care Price and Quality Transparency Rule, H-2007-05 Sec. 4(3) (A) through (E).

Because the consumer is logging into his/her own insurance company's database, the information to be received by the consumer is far more personalized information than under Model 1. The information provided would be based on real-time rates rather than historical data. The insurer knows its own insured's liability levels, what is left on a deductible, etc., and what the insurer is paying particular providers for particular procedures.

III. Legal Analysis

This antitrust discussion begins with Vermont's stated goal to provide health care cost transparency to its citizens. Vermont has passed laws and regulations designed to carry out its plan and vision. For example, 18 V.S.A. §9410 (2) (A) provides for the creation of a "consumer health care price and quality information system designed to make available to consumers transparent health care price information..." Under BISHCA Rule No. H-2007-05, health insurers are responsible for providing consumers with certain price information. The antitrust analysis acknowledges the tension between public access to health care cost information and the possible disclosure of competitors' pricing/cost information.

In general, the sharing of providers' pricing information raises two kinds of antitrust concerns: first, that the availability of one another's pricing information could lead competitors to engage in price-fixing; and second, that the availability of such information may stabilize prices and facilitate coordinated behavior. Based

on the information provided to me to date by the State Auditor, those concerns should not be an issue here.

A. The Antitrust "Safety Zone" Factors

In August 1996, the Department of Justice and the Federal Trade Commission jointly published *Statements of Antitrust Enforcement Policy in Health Care*. ("Statements") While the publication is dated, its principles still hold. The Statements discuss an antitrust "safety zone". If one provides health care pricing information within the parameters of that safety zone, the antitrust laws will generally not be deemed to be violated. In order to qualify for the safety zone, three conditions must be satisfied:

1) data collection must be managed by a third party such as the government;

2) information shared by, or available to, competing providers must be more than three months old; and

3) there must be at least 5 providers furnishing the data upon which each statistic is based, no provider' data may represent more than 25% on a weighted basis, and the information must be sufficiently aggregated so that the recipients are unable to identify the prices charged by any individual provider.

B. Application of the "Safety Zone" Factors to Model 1

As I understand Model 1, the first two conditions will be satisfied. First, the data collection will be managed by the State of Vermont. As a result, the insurers will not have access to one another's actual pricing data. This avoids the antitrust concern that competitors will use the price data to communicate with one another to fix prices.

Since the data is approximately 6 months old, the second condition will also be met. In addition, since the use of aggregate data is generally viewed, in the antitrust world, as an indicator that competitors will not/are not colluding by sharing actual price/cost data, the use of median price information helps to keep the model within the safety zone.

Based on the information available to me, it does not appear that Model I will automatically clear the third hurdle. VHCURES reflects data for 14 Vermont Community hospitals, as well as other providers and hospitals (including Dartmouth Hitchcock) located inside and outside of Vermont that service

Vermonters. It is my understanding that Fletcher Allen's patient revenue accounts for approximately 50% of the patient revenues for the 14 Vermont community hospitals. That figure is not weighted to include all VHCURES providers and hospitals. If the State wishes to pursue Model 1, additional information about the VHCURES data, including the percentage of the services and procedures data represented by other providers, whether there are procedures or services for which Fletcher Allen generates less of the revenue, etc. will be necessary. Without knowing what that data looks like, it is impossible to predict what the antitrust analysis will show.

Antitrust analyses often have some "wiggle room". The strength of the facts on first two factors might provide some breathing room on the third, but that is unpredictable at this time.

C. Antitrust Analysis of Model 2

Given that consumers will be obtaining pricing information directly from their own insurers on (presumably) secure websites accessible only by inputting one's personal identification number, the pricing information will not be publicly available or shared by competitors. As a result, antitrust concerns are not raised.

I would note that if Model 2 is chosen, all appropriate contract issues should be vetted to be certain that the State is not inadvertently requiring changes to contract terms that cannot currently be modified. For example, based on the terms of existing contracts, the State may only be able to establish a prospective requirement that insurers build price transparency tools. I have not reviewed the relevant contracts (nor am I suggesting that I am qualified to do so), but I raise this issue for the sake of completeness.

cc: Susan Mesner, Vermont Assistant State Auditor
Andrew Stein, Executive Assistant, Office of the Vermont State Auditor

VERMONT

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April 30, 2014

Douglas R. Hoffer, State Auditor
Office of Vermont State Auditor
132 State Street
Montpelier, VT 05633-5101

Re: GMCB feedback on Draft report entitled *Green Mountain Care Board VHCURES: Past, Present & Future*

Dear Doug,

Thank you for the opportunity to provide feedback on the Draft Report of the Vermont State Auditor, *Green Mountain Care Board VHCURES: Past, Present & Future*.

The Vermont Health Care Uniform Reporting and Evaluation System (VHCURES) is a vital tool for the Green Mountain Care Board (GMCB) to carry out its health care reform and regulatory responsibilities. We appreciate that the Vermont State Auditor has highlighted the value and importance of VHCURES as a resource for policy making, health improvement, cost information, and advances in health care quality.

Below and attached please find our comments in response to the draft report. Our comments below address some over-arching, thematic issues we identified in the draft. The attached spreadsheet sets out more specific issues and provides suggested language changes in many instances.

Resources, workload, and feasibility: The draft recognizes that the GMCB only assumed responsibility for VHCURES in July of 2013, lists the personnel involved with VHCURES, and explains the transition process the GMCB is currently engaged in as the current VHCURES contract approaches its August 2014 expiration date. However, the draft report does not adequately tie together these factors and the GMCB's time and resource constraints in addressing the feasibility of implementing a new price transparency initiative. The analysis beginning on page 24 reviews the legal and conceptual feasibility of this type of initiative, but does not address operational feasibility in light of the Board's current resources and workload.

Further, on page 19, the report notes that "GMCB personnel say they don't presently have adequate resources to implement and enforce the information system called for in statute."[1] We believe that the thorough research and information-gathering that went into the draft report shows that the GMCB has been in charge of VHCURES for less than a year,

[1] In addition, footnotes 49 and 50 refer to "written testimony" by DFR counsel and GMCB counsel. We suggest using a word other than "testimony" here, as it is a legal term of art referring to statements made under oath. We suggest simply citing the correspondence that supports each footnoted statement.

and during that time has been developing its processes, procedures, and staff. Further, your research regarding the transformation process we are engaged in as we prepare to solicit bids to succeed the current VHCURES contract demonstrates that the GMCB is adjusting its expectations, capacity, and vision for VHCURES, and will need to continue doing so for some time as a new solution is implemented. These tasks, in addition to administering the daily needs of the database and its users, are formidable, given our staffing levels. We believe this ought to be more explicitly addressed in the report, perhaps at the conclusion of the "History of VHCURES" section.

RFP process: In the "Objective 2" section on page 15, the report comments on possible components of an RFP. We request that discussion of the RFP be omitted until after the release of the RFP because of the potential to jeopardize the procurement process. We hope that the RFP will be released very soon—we have finalized the document and are waiting for approval by CMS. Also, we intend to issue a single RFP that will solicit separate responses for the lockbox and data aggregation functions, not two RFPs as stated in the report.

Data validity: The report comments on the uncertain validity of the data without fully explaining the GMCB's efforts to improve data quality in the short period of time that it has had the authority to address this issue. Indeed, the GMCB contracted with Truven Health Analytics in 2013, in part to assess the reliability of the data and to improve data quality. In addition to its contract with Truven, the GMCB incorporates data validation into its scope of work and the planned scope of work for future contractors working with the data. We believe studying the accuracy and reliability of the data is a necessary step to inform reform efforts and transparency.

Data release and governance: The discussion at pages 13-14 does not adequately describe the GMCB's process for controlling the release and use of VHCURES data, for at least two reasons: First, the language used in this section ("many VHCURES records are scattered across state government"; "inability to monitor data utilization") create the mistaken impression that the Board lacks processes for controlling the release and use of VHCURES data. In fact, under the Board's requirements for obtaining a Data Use Agreement authorizing access to VHCURES data the applicant must specify the exact uses contemplated for the data, as well as the data elements needed to accomplish that use. Therefore, we do not agree that the Board lacks the ability to control data use, and we believe the characterization of records "scattered across" state government is not a fair depiction of our efforts around data release.

Second, we believe this discussion should acknowledge the VHCURES transformation process as it relates to this topic. As the draft report notes at page 16, one of the aims of the transformation process is to "[e]liminate multiple versions of the database that are a result of the current decentralized data distribution system." The report's discussion of management and maintenance of the database should take into account the fact that the Board, in the relatively short time period since receiving authority over VHCURES, has put a plan in motion to enhance the State's ability to control and track the use of the data.

Again, thank you, and your staff, for the hard work that culminated in this report. We will use the report as additional input as we continue the process of transforming VHCURES. We hope you will incorporate our feedback as you refine the draft report into a final version. We welcome the opportunity to meet with you and your staff to discuss our feedback if you would find such a meeting helpful.

Sincerely,
s/ Alfred J. Gobeille
Alfred J. Gobeille
Chair, Green Mountain Care Board

Cc: Susan Mesner, Office of State Auditor
Andrew Stein, Office of State Auditor

DOUGLAS R. HOFFER
STATE AUDITOR

STATE OF VERMONT
OFFICE OF THE STATE AUDITOR

May 5, 2014

Alfred Gobeille, Chair
Green Mountain Care Board
89 Main Street
Montpelier, VT 05620

Dear Al,

Thank you and your team for the time and energy that went into your review of our draft report. While many clarifications you provided are helpful, we will need documentation to substantiate some of the suggestions. We plan to complete our review of your comments within a week and will provide you with a list of the clarifications that need substantiation. We hope that your team can turn this around quickly as we would like to complete this report as soon as possible.

In the meantime, we have some questions about the use of VHCURES data by Accountable Care Organizations (ACO). We understand that the state signed contracts in March with OneCare Vermont ACO, LLC and Community Health Accountable Care, LLC. It appears that the state agreed to give the parties VHCURES data.

1. Can you tell us which entities will have access to VHCURES data? That is, do all of the member hospitals and providers have access to VHCURES data?
2. Have the ACO's been required to sign VHCURES data use agreements and affidavits? If so, please provide that documentation.

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3. What data will these files include? Will the ACOs receive VHCURES extracts that include commercial claims? When a provider views these files, what is the scope of that view (i.e., limited to certain providers, limited to certain payers, limited to certain procedures, etc.)?

And, finally, Chairman Gobeille's letter referred to resource constraints as a barrier to advancing the legislature's goal of creating a price and quality information system to empower consumers. First, we understand that the Board has many other responsibilities and limited resources. However, the Board and its predecessors have devoted considerable resources to all of the goals identified in 18 VSA §9410 except the one regarding expanded consumer access to information (see the Table on page 8 of the report). If the Board discussed this issue prior to the initiation of this inquiry and/or sought additional resources for these purposes, please provide supporting documentation.

Sincerely,

Doug Hoffer

Doug R. Hoffer
Vermont State Auditor

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May 6, 2014

Douglas R. Hoffer, State Auditor
Office of Vermont State Auditor
132 State Street
Montpelier, VT 05633-5101

Re: GMCB feedback on Draft report entitled *Green Mountain Care Board VHCURES: Past, Present & Future*

Dear Doug,

I am writing in response to the two topics about which you requested follow-up in your letter dated May 5, 2014. Specifically, you asked for more information concerning "the use of VHCURES data by Accountable Care Organizations (ACO)" and you requested "supporting documentation" regarding the Board's resources.

ACOs' access to VHCURES data: In your letter, you state that you "understand that the state signed contracts in March with OneCare Vermont ACO, LLC and Community Health Accountable Care, LLC." First, I'd like to clarify this statement from the Board's perspective. The Board signed an exhibit to the program agreements that each ACO signed with each commercial payer as part of the commercial shared savings program developed under the Board's supervision. The exhibit sets forth the Board's oversight and evaluation roles with respect to the commercial shared savings program. The Board is not a party to the program agreements signed by each ACO and each payer.

Your letter goes on to state that "It appears that the state agreed to give the parties VHCURES data." This is not the case. Neither the exhibit signed by the Board nor the terms of the program agreements themselves grant the ACOs or the payers access to VHCURES data. Any shared savings program participant, whether an ACO or a payer, would have to apply for and obtain a DUA in order to access VHCURES.[1]

Resources: Your letter states that "the Board and its predecessors have devoted considerable resources to all of the goals identified in 18 V.S.A. § 9410 except the one regarding expanded consumer access to information." You then ask for supporting documentation showing that the Board discussed this issue prior to the beginning of this inquiry and/or sought additional resources.

[1] The Department of Vermont Health Access, as the State's Medicaid office, has signed program agreements with OneCare and CHAC as a payer, as part of the Medicaid shared savings program. Those program agreements also do not grant the ACOs access to VHCURES data.

As an independent public body tasked with a considerable list of duties, the Board must constantly review and set priorities. Since assuming responsibility for VHCURES in July 2013, our priorities have largely been driven by necessity: First, we inherited an ongoing government program with day-to-day needs and requirements, and, therefore, our top priority has been to keep it running at a high level. Second, given the timing of the OnPoint contract, we have also had to devote significant time and resources to procuring a successor to that contract. Of necessity, those two substantial tasks have been our top priorities for VHCURES.

At the same time, however, we have taken steps to improve the database in ways that will make it better-suited to provide expanded consumer access to information. For example, Truven, as part of its contractual work for the Board, is improving the quality of the data, thereby enhancing its value as a source for consumer information. Second, the procurement process will advance this goal further, because the RFP will require bidders to develop and propose additional solutions to data quality issues. As we complete the RFP process, and the process of implementing the next generation of VHCURES, we will look for ways to provide access to meaningful information likely to inform and assist consumer health care decisions.

Thank you again for your and your staff's effort on this project. I and my staff will respond as promptly as possible to the clarifications you mentioned in your letter, and we are available to meet if that is helpful.

Sincerely,
s/ Alfred J. Gobeille
Alfred J. Gobeille
Chair, Green Mountain Care Board

Cc: Susan Mesner, Office of State Auditor
Andrew Stein, Office of State Auditor

DOUGLAS R. HOFFER
STATE AUDITOR

STATE OF VERMONT
OFFICE OF THE STATE AUDITOR

May 15, 2014

Mr. Al Gobeille
Chairman, Green Mountain Care Board
89 Main Street, Third Floor, City Center
Montpelier, Vermont 05620

Dear Al,

We have completed our review of your staff's comments and recommended changes. Your team's insights were very helpful, and we have decided to make many of the changes you recommended. For seven of those proposed changes, we are requesting further information. Please see the attached excel document labeled "SAO Request for Further Information (GMCB VHCURES)."

With regard to the RFP, it is neither our intention nor our desire to jeopardize your procurement process. From the outset of this inquiry, we have made clear that one of our objectives is to identify what plans are in place for a new version of the database. We are willing to work with the board on this section of the report to meet our objective, while respecting the integrity of your procurement process. For that reason, we are providing you our proposed changes to that section (in Track Changes), which are included as an attachment. We do feel that the report should highlight the board's general plans and at least acknowledge that an RFP is forthcoming.

Lastly, we would like more information about the data that commercial insurers are or are planning to share with ACOs. The agreements that Mike Donofrio sent Andrew Stein last week indicate that the Vermont ACO Data Use Standards were still under development (pg. 25 of the agreements) when the ACOs and insurers signed the contracts in February. Have those data use standards been established since the agreements were signed, and if so, could you please provide them? We are also interested to know whether commercial payers have provided ACOs data for their attributed patients. Please provide us with any and all documentation related to the exchange of claims data from commercial insurers to Vermont ACOs.

Thank you for responding promptly to our previous requests. If your team could continue to respond in this manner, we can complete our work in the very near future.

Sincerely,

Doug Hoffer

Douglas R. Hoffer
Vermont State Auditor

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VERMONT

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May 27, 2014

Douglas R. Hoffer, State Auditor
Office of Vermont State Auditor
132 State Street
Montpelier, VT 05633-5101

Re: GMCB feedback on Draft report entitled *Green Mountain Care Board VHCURES: Past, Present & Future*

Dear Doug,

I am writing in response to your letter dated May 15, 2014. First, attached please find an annotated version of the Excel document you sent us, along with four documents (two Excel documents with titles "APCER…" and "BI Tool…" and two PDFs (interagency MOA and Hersey affidavit)). Those documents should provide all the information requested on the spreadsheet you sent.

Next, we appreciate the revisions you made with respect to the RFP. We are comfortable with your revised language.

Finally, you asked about the current status of the ACO Data Use Standards. Our staff, working with relevant stakeholders, is moving towards finalizing those standards as well as a document laying out the data use reporting requirements for ACOs and payers. Attached please find the most recent versions of both documents (Word documents entitled "ACO data use standards 2014 5-22" and "data use reports 2014 5-19…"). Please note that, although these are drafts, we do not anticipate significant changes. Once finalized, our staff will present them to the Board for approval. These documents comprise our response to your request for documentation related to the exchange of data.

Sincerely,
s/ Alfred J. Gobeille
Alfred J. Gobeille
Chair, Green Mountain Care Board

Cc: Susan Mesner, Office of State Auditor
Andrew Stein, Office of State Auditor

Appendix C: GMCB Detailed Comments on Draft VHCURES Report and SAO Responses

The following table outlines the Green Mountain Care Board's detailed comments on the draft VHCURES report and the Office of the State Auditor's responses. Comments from the GMCB were sent to the SAO in excel format and included some additional information pertaining to the draft report, such as page numbers, which were omitted from this table. For readability purposes, we combined and reformatted the board's comments and our responses. All of the detailed comments and recommended changes are verbatim from the board and the SAO.

Report Section	GMCB Detailed Comment	GMCB Recommended Change	SAO Response
Background	BISHCA is not technically defunct but has been renamed.	…Regulation H-2008-01 adopted by the Department of Banking, Insurance, Securities and Helath Administration and renamed as the Department of Financial Regulation (DFR).	We agree to replace the word "defunct." We do not agree that BISHCA was simply renamed. The department was given a new name as the Legislature shifted key resources and health care regulatory authorities to the Green Mountain Care Board, including hospital budget review, insurance rate review, management of VHCURES, the expenditure analysis, and so on.
Background	Vendor does not "oversee" the distribution of VHCURES data. GMCB provides oversight and the vendor provides the logistical services of producing and shipping authorized data extracts.	The board has a contract with Onpoint Health Data to manage the collection, aggregation, warehousing, and distribution of data extracts authorized for release by the board.	We agree to change the word "oversee" to "manage."
Background	Suggest a final sentence that summarizes how much of the insured population is currently captured in VHCURES.	Add as last sentence: VHCURES is representative of over 90 percent of the commercially insured and 100 percent of Vermont residents covered by Medicaid and Medicare.	Thank you for bringing this to our attention. Can the board please provide supporting documentation that "VHCURES is representative of over 90 percent of commercially insured Vermonters?"

Background	Need additional technical clarification on the current encryption process pertaining to specified identifiers.	Names of insured members, social security numbers, contract numbers, and other member identifiers are encrypted by commercial insurers and the Medicaid program before the data are submitted to Onpoint.Onpoint then encrypts the data submitted by commercial insurers and Medicaid again resulting in a double encryption. Onpoint encrypts the Medicare data submitted by the data distribution contractor for the Centers of Medicare and Medicaid Services (CMS) under a data use agreement between CMS and the board.	We agree to make a clarification to this effect.
History of VHCURES	Need additional clarification on the history and current status of the hospital data programs.	By 1992, the had roughly two decades of experience collecting and analyzing hospital discharge records in what is currently called the Vermont Uniform Hospital Discharge Data Set (VUHDDS). These data continue to provide information limited to hospital-based utilization and charges for services but not what was actually paid by different insurers or the uninsured.	We agree to make a clarification to this effect.
History of VHCURES	During the late 1990s BISHCA tried a voluntary approach with major insurers to develop a prototype claims data reporting system but the effort was short-lived.	Last sentence: During the late 1990s, BISHCA convened a few major insurers on a voluntary basis to develop and test a prototype for a uniform claims reporting system but the effort was short-lived. CMS was not supportive of contributing Medicaid data towards such a state-based effort at this point in time.	Thank you for bringing this to our attention. Could you please provide documentation of this effort?

History of VHCURES	Pertaining to the two prior issues above, Act 171 was the historic moment for converting a "may" to a "shall" for claims data collection. Key concept that finally got VHCURES off the ground.	Add second sentence: This was historic since under prior legislation pertaining to the unified healthcare database, the requirement to collect claims data from commercial insurers was not mandated but at the discretion of HCA.	We agreed to make a clarification.
History of VHCURES	Vendor does not "oversee" the distribution of VHCURES data. GMCB provides oversight and the vendor provides the logistical services of producing and shipping authorized data extracts.	...Onpoint Health Data to manage the collection, aggregation, warehousing, and distribution of data extracts authorized for release by the board.	We agree to change the word "oversee" to "manage."
History of VHCURES	Need additional clarification on the role of CMS for both Medicaid and Medicare data inclusion in VHCURES.	Rewrite: In 2011, VHCURES expanded to include Medicaid claims. CMS approved an agreement between the Department of Vermont Health Access, which oversees the state's Medicaid program , and BISHCA to incorporate Medicaid data into VHCURES.	We agree to make this clarification, but we need the referenced agreement and the approval from CMS to do so.

Inquiry Objectives	Objective 3 is "*To assess the extent to which the database could be used to provide greater transparency of health care costs and to better inform consumers of the price of specific medical procedures*." A significant amount of the section of the report dedicated to this objective and the evidence presented there (pp. 16-27) deals with the ways that private insurance companies can increase transparency using their own data rather than how the state could use VHCURES data for this purpose. This is a significant divergence from the stated objectives of the inquiry.	The report should focus on what VHCURES specifically can do to increase transparency, and on evaluating the evidence around the expected impact of such an iniative.	The Green Mountain Care Board's use of insurance claims data should not be limited to examples set by itself and by other governments. The private sector is currently providing numerous opportunities for consumers to identify higher value options of care. The board might glean some ideas about how to better use claims data for consumer purposes by understanding what the private sector has accomplished on this front. As the board seeks to overhaul VHCURES, the SAO wanted to provide the board a range of examples for how such data might be used to better inform consumers. We added language in the report to this effect.
Objective 1: Use of VHCURES (Users and Access)	The report states that the GMCB and predecessors have not addressed providing information to consumers and purchasers of health care. While the scope has been limited, the GMCB has prepared reports and worked continuously to better inform the expenditure analysis using VHCURES data.	Language should be changed to reflect this is a work in progress and that there are numerous efforts to improve reporting in the Expenditure analysis and for payers (purchasers of health care). In additon, work ahs been done by the Blueprint and Medicaid.	Although the GMCB and its predecessors prepared some public reports using VHCURES, all of the identified products were for policy purposes, not consumer purposes. The Expenditure Analysis, required under § 9375a, is a valuable tool used for health care policy purposes. As the statute states, the analysis "shall be used as a tool in the evaluation of health insurance rate and trend filings with the department of financial regulation, and shall be made available in connection with the hospital budget review process." We do not view this report as a consumer information tool used to empower patients, as §9410 calls for. Furthermore, we

			did not receive sufficient evidence to determine that using VHCURES to inform consumers of health care price and quality information is "a work in progress."
History of VHCURES	Need additional clarification on distinction between the CMS DUA for Blueprint and the CMS DUA for State Agencies and Broad Use.	Rewrite: In 2013, CMS granted a separate data use agreement to the board allowing a broader use of Medicare data to support the state's analytical needs related to health care reform. The board was granted the discretion to re-distribute the Medicare data to other Vermont state agencies and state contractors performing work that is directed by the state. The Medicare data are scheduled to be fully integrated and available for release as authorized by the board in April 2014.	We agree to make a clarification to this effect. What entities currently have access to this data? When was Medicare data incorporated into the database?
History of VHCURES	Add effective date for transfer of VHCURES to GMCB	Last sentence: Two years afte the creation of the new regulatory body, the legislature moved responsibility for VHCURES to the board effective July 2013.	We agree to add this date.
Users and Access	Need to strenghten the relationship between data use agreements and data user affidavits. All affidavits are associated with DUAs	First sentence: Since 2010, more than 250 individuals have had access to the VHCURES data as authorized by signatories to VHCURES data use agreements.	We added additional language that better explains the relationship between data use agreements and affidavits. We did not use your recommended change.

Users and Access	Need to recognize the complexity of these data that will not be completely solved by a BI Tool. The coding differences for similar services reflect business practices of the providers and insurers and not due to VHCURES.	Rewrite: Claims data are rich but intrinsically complex requiring that record-level users are highly trained and educated in its use. The absence of trained employees and a user-friendly interface, such as business intelligence tools for analytics as cited by state employees, are barriers to accessing the data. Another barrier employees noted are difference in coding for similar services and products. This is due to non-standard business practices among the providers who bill insurers and the claims that reflect those transactions.	We agree to clarify this.
Users and Access	Need additional clarification on the data release process that has always required a data use agreement between the state and every entity licensed to use the data.	Rewrite: In 2011 in addition to the data use agreements between the state and authorized users, the state began requiring that every data user associated with a data use agreement file a data user affidavit.	We agree to clarify this point.

Users and Access	Need additional clarification on the data release and acquisition process.	Rewrite: End the first sentence at the first comma. Non-state entities may apply for limited use research data sets and are required to provide detailed information regarding intended research objectives and to justify the use of specified data as necessary to support meeting the research objective. To meet conditions set by CMS, AHS and DVHA must approve any requests for use of Medicaid data. Under the CMS data use agreement with GMCB, non-state entities are prohibited from access to the Medicare data. GMCB does not have the statutory authority to charge fees for the data. Non-state entities pay the state vendor Onpoint $5,200 for customized extracts of up to 5 years worth of data. Make new paragraph for following- Vermont state agencies apply for and obtain "broad use" data use agreements from GMCB for flexibility in meeting the state's analytical needs. Vermont state agencies currently have access to both commercial and Medicaid data. CMS granted GMCB the discretion to approve future release of Medicare data to other Vermont state agencies and their designated contractors. State agencies may receive extracts updated on a quarterly basis for a fee of $515 paid to Onpoint.	We have made an additional clarification to this effect.
Objective 1: Use of VHCURES (Users and Access)	The report describes the lack of a business information tool to help with use of the data. There has been an attemtp to build that tool. Staff tested a business tool and found it lacking.	The report should acknowledge the attempt to have a business tool built. More importantly, the sophistication and scope of this data set should be described to put the difficulty of building such a tool in context.	Thank you for bringing this to our attention. Could you please provide documentation of this effort, including any contract for such work and any staff analyses that explain why the tool was lacking? If you cannot provide such information, please provide us with an

			explanation of this project and where we might find evidence of this effort.
Objective 1: Use of VHCURES (Users and Access)	The first paragraph of the users and access section ends "*Although the SAO was able to identify at least one state employee who was proficient in using the public insurance side of the database, the SAO did not identify a state employee who was proficient in using the private side.*" It is unclear what the report means by the private side of VHCURES. Medicaid and Commercial data are nearly identical (Medicaid contains certain fields that commercial does not, but this difference is inconsequential to a user's ability to work with the data in most cases).	Blueprint analyses, to include the 2013 annual report available on the website (URL provided), contains information about the commercially insured drawn from VHCURES. Craig Jones is a state employee and an experienced user of the VHCURES data.	An SAO representative met with Mr. Jones to better understand the Blueprint's use of VHCURES data, and he had repeated discussions with Mr. Jones about the Blueprint's use of VHCURES. Our office reviewed DVHA's contract with OnPoint (and the five amendments), and Mr. Jones provided us with examples of work products OnPoint produces for the Blueprint's evaluation processes. What we found is that OnPoint works directly with VHCURES for the Blueprint team, producing various data analyses and reports. The Blueprint then uses OnPoint's products for programmatic purposes, such as evaluation. While Mr. Jones and his team work very closely with OnPoint, Mr. Jones showed us that he himself does not directly use the VHCURES database.
Users and Access	Need additional clarification on the data release and use process.	Rewrite second sentence: The agreements place the burden on the signatories who may be the requestor (agency or organization executive) and the requestor's designated principal investigator to abide by the board's conditions of use.	We agree to clarify this point.

Users and Access	Improve clarity.	To clarify current governance that sets the stage for the access protocol, the title could be, Routes to GMCB VHCURES. For the second level of DUA boxes, change the labels to "State Agency Data Use Agreement" and Non-state Entity Data Use Agreement." for the third level of boxes, add Data User Affidavits over the users associated with each DUA type with set of arrows pointing to the DUA boxes on the second level.	We clarified that the data use agreements are for "state entities" and "non-state entities." We included a caption below the figure, which states: "The GMCB requires individual data users to sign an affidavit before using VHCURES on behalf of their organization." The diagram is for organization access, as the caption states.
Users and Access	Improve clarity of the facts. NVRH did not have access to the entire data set.	Rewrite: To date, only one insurer has applied and then withdrew an application for the data. One insurer trade organization was granted access. On the provider side, the Vermont Association of Hospiitals and Health Systems was approved for access as a state contractor on a study. Northeast Vermont Regional Hospital was permitted to review a subset of claims data for that NVRH under the DVHA data use agreement.	Neither the board nor DVHA provided any evidence of how NVRH used VHCURES. We have no way to substantiate that NVRH received access to only a subset of the database. Could you please provide documentation to substantiate this claim? Additionally, one board comment in your detailed comments states: "For NVRH, there was no payment to them under the DVHA contract." The SAO has in its possession a contract between NVRH and the State for a grant not to exceed $343,661. Is the board asserting that the state did not pay NVRH any of that grant amount? Please elaborate on this comment.
State and Non-state Use	Several Max amounts are incorrect in relation to analytics and would be	For VAHHS-NSO, the max allowed also includes the hospital data collection and aggregation. Payment Variation I is only part of the Max and	We initially noted on the previous page that the max contract amounts were not always indicative of the cost of analyzing VHCURES.

	misinterpreted.	Mike would have the final figure on that paid amount. For NVRH, there was no payment to them under the DVHA contract. NVRH just review some data for the Blueprint evaluation in their service area.	We moved this language to the same page as the matrix. With regard to NVRH, please see the above response.
Objective 1: Use of VHCURES (Users and Access)	Same comment as row 31.	A lot of the contract work that has been cited is still work in progress that is designed to build a usable taxonomy for improved reporting to support policy development, ongong trending and benchmarking, to provide a deeper dive of how and why spending is changing by age, region, geography, etc. This will support reports for ALL USERS OF THE DATA.	
State and Non-state Use	Inadequate description of how GMCB uses VHCURES data to address statutory duties and innovation.	Rewrite: Contractors assist the board in carrying out regulatory and innovative functions including ensuring availabilty of accessible health care resources and services through certificate of need review; cost montoring and containment through insurance rate review and hospital budget review; payment reform that supports both cost containment and quality of care.	We added an elaborative sentence.

State and Non-state Use	Does not accurately capture what was posted for several years	Rewrite second sentence: The two main reports generated by Onpoint were the Healthcare Utilization and Expenditure Report reported by insurer and services area comparing demographics, health status, spending, utlization and the "Report Card" with demographic, risk and quality process measures reported by service area.	We do not feel that this extra level of detail strengthens this section of the report. We mention that OnPoint provided "a wide range of utilization and expenditure analyses." The table is meant to give the reader a quick and easy understanding of how different state entities and their contractors used or are using VHCURES.
State and Non-state Use	Clarify deliverables.	Delete coordinating data use across state agencies. May be more accurately stated as, "providing technical assistance on data use and analyses at various state agencies." Policy Integrity also provides ad hoc data analysis for GMCB.	We agree to clarify this point.
Objective 1: Use of VHCURES (Users and Access)	Non-state entity use of VHCURES chart does not specify what information various parties were given, and omits some users. Specifically, the entity for AHIP should specify that the group was given a limited extract which did not include full payment information, and NVRH (which was ommitted entirely) was allowed only to see entries for care provided at NVRH to help DVHA understand some unexplained spikes in the data.	ADD: AHIP was given a limited data extract for this purpose, which did not include NVRH was given access to information only about its own operations. DVHA worked with the hospital to better understand unusual patterns in the data.	We will qualify that AHIP was given a limited extract. The board or DVHA must provide further information about NVRH if you want the report to include such qualifications. Also, NVRH was not included in the non-state entity matrix that this comment pertains to.

Management and Maintenance	Object to the first paragraph that insinuates that data were released by Onpoint without the state being aware. Not one extract has ever gone out without the knowledge and authorization of staff.	Rewrite: Onpoint releases both one-time extracts to authorized non-state entities and quarterly extracts as requested to Vermont state agencies after the state approves each file release. However, Vermont state agencies have the discretion to release extracts directly to their designated state contractors. Therefore, the Auditor's office was unable to compile a complete record of every user who was provided with a state data extract. State contractors are notified by GMCB (BISHCA and DFR in the past) reminding them to update the filing of affidavits as needed. Although the state has always required data use agreements for every non-state entity and Vermont state agency for access to VHCURES, the state does not have a complete log of data extracts distributed by Vermont state agencies to designated contractors.	**Response to detailed comment:** This may be true, but the manage state entities do not have the records to prove it, which is what the statement says. **Response to recommended change:** The paragraph in the report is a statement of fact about record keeping.
Management and Maintenance	It is the current use of encrypted hard drives as the means for releasing data and lack of existence of a hosted data warehouse that is the root cause for decentralization.	Add second sentence: The primary reason that the data reside at scattered locations is that encrypted hard drives is the current option for releasing extracts.	We added a sentence to reinforce this point.
Objective 1: Use of VHCURES (Users and Access)	Characterization of "scattered" data is innaccurate.	The data has been distributed to qualified users who have signed DUAs.	We have clarified this point. We wrote that "records are scattered across state government"; not data. By records we are referring to contracts, work products, and other agreements that indicate how different data users have or are using VHCURES.

Objective 1: Use of VHCURES (Users and Access)	This paragraph implies that the GMCB does not know where the data is. While the GMCB does not know where each hard drive is at any given time, it knows who data has been given to, and who those users are authorized to share it with. The paragraph also asserts that anti-trust concerns attach to the sharing of VHCURES data with organizations that have self-interest in the health care system if they also attach to the release of cost information to consumers. This ignores the fact that these parties were given limited extracts.	Acknowledge that the board can monitor a larger set of users that are actually using the data at any given time (There are N users sharing M hard drives, with N>M). The board can constrain the data use to the N users and regulate them as though each of those N users has the data at any given time, and because it authorizes who data users can share data with (subcontractors must also have DUAs), it can further restrict which sub-users can use either full or partial data sets.	The SAO does not dispute that the board knows what users are authorized to use VHCURES data. The SAO's point is that the board has no way of identifying a deviation of that use. Furthermore, the logic that because data was released on M number of hard drives ignores the reality that data can be duplicated onto other drives and sent to new users without the board knowing. This logic also does not address the potential for a data user to use the data for purposes other than those stipulated in the data use agreement. Furthermore, the state lacks a complete log detailing the distribution of VHCURES data extracts, which would be central to tracking how the data has been distributed to N users.
Objective 1: Use of VHCURES (Users and Access)	The report states that over $4 million has been spent on Onpoint. And the report identifies another +$3 million for analysis and a vague amount of "millions" for other contractors. The statement does not acknowlege the deliverables and does not place them in the context of the State's work.	The GMCB has sound contracts that were vetted through the state RFP and DII review process along with a variety of other oversight by managers in the review process. The GMCB can point directly to very specific reports and functions that have been done to collect the data, manage the data, design the data for information purposes, etc.	Although this section of the report does not touch on deliverables, many of the pages leading up to this section do. We mention OnPoint's work throughout the project. "The vague amount of 'millions'" is referenced in the matrix on page 10, and we will direct readers' attention to this. It was not an aim of our inquiry to list all deliverables related to these contracts. We reviewed dozens of deliverables and summarized this work on pages 11 and 12. We did not question the board's contracting processes, although some contracts were awarded sole-source and not via an RFP process.

Objective 1: Use of VHCURES (Users and Access)	Left out Executive before Director.	Change to Executive Director.	We agree to change this.
Objective 1: Use of VHCURES (Users and Access)	The report should not detail the plans for the RFP.	Remove information describing RFP.	We re-wrote paragraphs 1-3. The revised report does not detail the plans of the RFP process, but we do mention that the board is preparing an RFP.
Objective 2: Plans for a new VHCURES	RFP plans have changed.	The RFP should not be discussed publcly because of the potential impact on the procurement process.	We have revised this section of the draft.
Objective 2: Plans for a new VHCURES	Ethnic background is cultural and Race is biological.	Replace Ethnicities with Race / Ethnicity	While this comment touches on a matter that is highly contested within the scientific community, we will agree to include language that the board is considering the categorization of data by race and ethnicity. Federal OMB Standards for Data on Race and Ethnicity are explicit that "The categories represent a social-political construct designed for collecting data on the race and ethnicity of broad population groups in this country, and are not anthropologically or scientifically based."
Objective 2: Plans for a New VHCURES	Need to further qualify the statement in the last sentence about the prohibition on public reporting of negotiated rates between insurers and	Add to last sentence: …explicitly prohibit making public the rates that insurers and providers negotiate at a level that would violate federal anti-trust provisions.	The language in the data use agreements and affidavits does not say "at a level that would violate federal anti-trust provisions." It is a blanket prohibition of making these

	providers.		rates public.
Objective 3: Consumer Information (Vermont's Health Care Information System)	Paragraph ends "*Additionally, the system provided very little quality information, and it was only available for three of 25 physicians tested at random*." This sounds as though the system was only available for 3 of 25 physicians, not the quality information.	*Additionally, the system provided very little quality information, which was only available for three of 25 physicians tested at random.*	We agree to clarify this sentence.
Objective 3: Consumer Information (Public and Private Transparency Initiatives)	Last sentence ends "*could find themselves paying as much as $12,700 annually for medical care on top of premiums and prescription expenses.*" Most exchange plans have integrated OOPMs (the prescription OOP cost counts towards the medical OOPM), and those that are separate have medical and Rx OOPMs such that the aggregate is $12,700 or less.	End sentence "could find themselves paying as much as $12,700 annually for medical care on top of premiums."	The OOPMs for this bronze plan are integrated. Thank you for pointing this out. We made the necessary correction.
Objective 3: Consumer Information (Public and Private Transparency Initiatives)	The paragraph reads "*Vermonters are given a greater incentive to make decisions based on the cost of care, but they are not given the tools to effectively weigh their options. Vermonters could use transparent price and quality information to identify higher value opportunities*." This diagnoses a problem, but assumes		This statement is part of a larger section, which plainly states that quality information is key to identifying higher value opportunities. The very statement quoted in the comment acknowledges that quality information is important for identifying higher value care.

	a solution without providing sufficient evidence. The SAO report assumes price transparency will lead to better consumer decision-making. The evidence from New Hampshire shows that consumers will do this (though that case also showed that financial incentives were also necessary), but this ignores questions about whether this information will affect provider-patient interactions (especially around whether the patient is getting the right care), and uncritically accepts the assumption that the lower cost care for specific services is better for the health care system as a whole. The SAO report does surface this issue, but does not treat it as a major part of the problem. The Ewe Reinhardt quote that the SAO provides on page 20 of the report moves beyond the emphasized portion [SAO's emphasis] to list 3 dimensions on which the information must be provided. The second of these is practice style. The SAO ignores this part of Reinhardt's argument.		The Legislature created a law that would provide consumers with price and quality information to make health care decisions if program managers implemented the statute effectively. The need for program managers to implement the statute is only reinforced by the fact that Vermonters are sharing a greater amount of health care costs today than they were five years ago. Nowhere in this report does the SAO accept the so-called assumption at the end of paragraph two that this comment refers to. What the SAO report does say is that by not providing consumers with relevant price and quality information, consumers have no means of identifying higher value care. With regard to Uwe Reinhardt's methodology, the SAO is simply providing methodologies for the board to consider. We agree that in addition to unit prices, the quantities of those units and associated services are crucial to informing a patient of his or her overall cost of care. The validity of this methodology is the very reason we decided to include this quote in the report and provide a link to his article. We do not ignore or dispute the importance of Reinhardt's argument.

Objective 3: Consumer Information	This section summarizes a variety of public and private transparency initiatives, but all of the examples given are for initiatives conducted by insurance companies using their own internal data. The SAO report does not support the idea that state transparency initiatives, rather than private insurance company ones, caused the change, and does not differentiate between changing the information offerred, which is the most VHCURES could do, and changing financial incentives, which was done by New Hampshire insurance companies. The section also cites a belief that it was the state's transparency initiative that changed the dynamic in hospital-insurer negotiations, though it is unclear why this was necessary because the insurers already had their own data showing the price descrepancy, and Exeter Hospital, which is cited specifically, is widely believed to be excessively expensive.	A number of private insurance initiatives in New Hampshire have introduced price comparison tools which, when combined with changes in plan structure which changed patient/consumer behavior. The study reports that this saved money by incentivizing patients to use ambulatory surgical centers and independent labs rather than hospitals, though it is unclear if this is replicable in Vermont due to the lack of these alternative services.	We agree to make a change to the effect recommended, but the board's detailed comment is problematic. The SAO report is intended to help the board meet its statutory duty of providing price and quality information to consumers; it is not an academic paper arguing in favor of public versus private transparency initiatives. The HSC report cited in this section makes the point that these private insurance initiatives cropped up after the public transparency initiatives, and many respondents cited a belief that these private initiatives were spurred by the state's leadership in the sphere of health care transparency. With regard to the Exeter negotiations, the report notes that stakeholders saw the negotiation balance shift when the hospital's high prices were thrust into the public eye.
Objective 3: Consumer Information	This paragraph states "*The 2013 study reports two chief findings: 1) public transparency initiatives began influencing hospital-insurer negotiations, and 2) insurers started to design plan benefits around information systems for price-*	The study found that 1) HealthCost did not increase consumer price-shopping, 2) Insurers started to design plan benefits with financial incentives to encourage patients to choose lower-cost services, and 3) Many people interviewed for the study attribute changes in hospital-insurer negotaitions to the state's	We agree to clarify these points, although the SAO report clearly states that "HealthCost and subsequent public price transparency initiatives did not stimulate a noticeable upswing in consumer price shopping." The two findings that are referenced stem from the section in the final

	conscious patients." These are not the main findings of the report. The closest that I can find to this language appears in the last sentence of the paragraph running from the end of page 2 to the beginning of page 3. The report does not appear to contain a stated set of main findings, but the closest that I can find is the following from the abstract. *Although price transparency initiatives did not directly induce significant consumer shopping, they helped change market dynamics in New Hampshire by focusing a spotlight on high-price hospitals, according to a new qualitative analysis by researchers at the former Center for Studying Health System Change (HSC). Changing market forces included a shift in health plan-provider negotiating power and a move toward private-sector health benefit designs with financial incentives to steer enrollees to providers with lower prices.* (Tu and Gourevitch, p. 1) The SAO presents the findings as at least equal, or with the implication that the first was the more important	transparency initiatives. The study does not address the fact that a number of other factors were influencing the health care market at that time. The Affordable Care Act had just been passed, so there was a significant amount of attention being paid to the health care system generally, and New Hampshire had just seen increases in insurance costs of 15% in its small-group market and 39% in the individual market (Highland, p. 2). The HSC follow-up study notes that some observers doubted that the state's price transparency initiative was the true driver of change as insurers were already aware of price variation from their own data, but they may have used HealthCost to make insurance purchasers more open to the new plan designs (Tu and Gourevitch, p. 6).	report titled "Heightened Awareness of Price Variation," which is the language you mention. The language that set the stage for the following sections in the report is: "Many respondents credited the changed market environment with helping to bring about two important developments in New Hampshire: a rebalancing of health plan-provider contracting leverage and a move toward new insurance benefit designs." These two developments are the focus of the first three pages of the report after the background section, and the remainder of the report builds from these developments.

	and led to the second. In fact the abstract of the paper follows the above sentences with *"These new benefit designs, especially in the small-group market, have proven more effective than public transparency efforts in spurring cost-conscious consumer behavior,"* and the study repeatedly states that these changes included changes to financial incentives. It states that the financial incentives made information tools more valuable, but repeatedly cites insurer-provided information sources, not HealthCost. The SAO report generally uncritically accepts the HSC report's findings that the increase in transparency was a driver behind changes in the New Hampshire health care market. This ignores the facts that 1) the fact that payments vary was already widely known to people in the health policy world and the insurers already had their own data to tell them this, 2) there were a number of other significant changes taking place in health care at the time (passage of the ACA, significant cost increases in small group and individual insurance markets), and 3) the fact that a study		

	looking at the impact of one particular transparency initiative contained a clear risk of prompting interview subjects to over-attribute changes to that initiative.		
Objective 3: Consumer Information	Regarding the above two key findings that the SAO highlighted: The SAO report also does not consider the following to be a key finding of the study: "*Consumer use of HealthCost has remained modest since the program's inception, and the program did not fulfill a primary goal of directly encouraging consumer price-shopping*" (Tu and Gourevitch, p. 1) (emphasis mine). In both the abstract and the body of the report, this finding is reported before the other two, though it is downplayed.	Suggested changes are included above.	The SAO does believe this is a key finding, and the first paragraph in the SAO report on this study addresses this issue. "HSC revisited HealthCost in 2013. The new study ... found that while HealthCost and subsequent public price transparency initiatives did not stimulate a noticeable upswing in consumer price shopping, it did influence New Hampshire's health care market." The lion's share of the Robert Wood Johnson Foundation report focuses on the other findings, but we did feel this finding was important enough to lead this portion of the report.
Objective 3: Consumer Information (HealthCOst Results)	The paragraph begins "*Anthem has subsequently designed plans around these high deductibles and its price transparency tool*." This is incorrect. Anthem introduced the tiered benefit design (Site of Service) in 2009 (Tu and Gourevitch, p. 4, last paragraph). It did not introduce its price-comparison tool	"*Anthem used its price transparency tool, which it augmented with financial rewards, to increase price-shopping by consumers.The company has created copayment tiers for certain products to encourage its members to choose providers that offer less expensive services, and members who elect to use a low-priced provider recommended by the program recieve a financial reward of usually around $100 (Tu and Gourevitch, p. 6).*	Thank you for pointing out this error. We will correct this language and include your recommended addition.

	(SmartShopper) until 2010, when it started to serve "large, self-insured employers." It was only launched to the fully-insured small-group market in 2013 (Tu and Gourevitch, p. 6).		
Objective 3: Consumer Information (Public and Private Transparency Initiatives)	Referring to plan incentives in NH which encouraged patients to use independent labs and ASCs, the paragraph states "*While this plan design can encourage lower cost behavior, residents living in more rural regions of the state will be less likely to benefit because they live close to only one provider and far from independent or freestanding facilities."* For purposes of the impact of competition in health care, Vermont has no non-rural areas (Burlington and Rutland are each served by a single dominant hospital), and only one ASC which is limited to providing ophalmalmic propecedures. The study of New Hampshire notes that there are few or no independent options for residents outside of the southeastern corner of the state or the lakes region.	While this plan design can encourage lower cost behavior, residents living in more rural regions of the state will be less likely to benefit because they live close to only one provider and far from independent or freestanding facilities. In the case of Vermont, almost the entire state falls into this categorization. There are no freestanding ASCs offering general services (there is one specialty ASC). No area has real competition for hospital services, though tiered pricing could prevent some patients from going to higher-priced New Hampshire hospitals (Littleton and Dartmouth).	We agree to include a clarification to this effect. It is worth noting that the RWJF report does state: "Recently, Anthem announced that two northern hospitals -- Androscoggin Valley and Upper Connecticut Valley -- have been designated as low-price options for both lab services and ambulatory surgeries, thus providing more alternatives for consumers."

Objective 1: Use of VHCURES (Users and Access)	The report describes what other states are doing, suggesting VT could/should do the same. However, it provides no sense of comparable resources across the states.	It is important to recognize that resources to developp and maintain the websites suggested could very well require greater resources that Vermont has or has devoted to this effort.	The board has a statutory duty to provide consumers with price and quality information, and the SAO provided public and private examples of similar systems. The SAO did point out the cost of building a transparency system based on a similar database in New Hampshire. Officials in New Hampshire indicated that the project has consumed the time of primarily one employee, who also spends time on other tasks.
Three Key Points	Point #2 should include a caveat that consumers need more clinical guidance to distinguish what may be more discretionary and preference-sensitive and what kind of care should not be foregone. #3 would benefit from recognizing the utility of criteria for prioritizing the types of predictable care and procedure for focusing full-bore transparency reporting.		Those three points surfaced from a literature review. Your points are valid points, and the SAO welcomes such refinements in the board's pursuit of creating a price and quality transparency system. We are not inserting these additions because they did not come from our review; we do, however, think they are important.
Objective 3: Consumer Information (feasibility)	The paragraph argues that, because the Blueprint computes quality metrics for participating physicians, these methods could be used for a future quality reporting system. There are frequently small n problems with reporting physician quality data at the individual practitioner level. At the same time, case-mix adjustment may		

	not be able to overcome the effects of patient selection, as a provider would only need to change his or her patient panel slightly to significantly change quality ratings. A 1999 study of physician report cards showed that, among physicians caring for patients with diabetes, differences between physicians were almost all within the margin for error, and a physician who was performing poorly could achieve normal results by dropping only 1 to 3 patients (Hofer et. al, 1999).		
Objective 3: Consumer Information (legal feasibility), and Appendix A	Under the SAO's second proposed model, an insurer would be able to determine the exact amount paid to providers for non-preventative services costing the insurer up to $20,999.98. To learn the details of insurer B's contract, insurer A could do the following: 1. Hire someone eligible for a family plan. 2. Enroll that person in insurer B's bronze HDHP family plan. 3. Have that person look up the various procedures that insurer A wants price information about. Math getting to the $21,000 is	Query whether this scenario raises anti-trust concerns. We have not analyzed this precise legal question, but wanted to share it with you for your consideration so you can determine whether to vet it with the Attorney General's Office.	The Principal Investigator of this report discussed this matter with the GMCB General Counsel.

	available on request.		
Objective 3: Consumer Information (legal feasibility), and Appendix A	The SAO's second option requires action only on the part of the insurer: public transparency work will not have an effect here.	As has been done in other states, price transparency work could be undertaken by private insurers rather than by the government. These insurers will have more up to date information, and will be able to incorporate information about an individual consumer's cost sharing requirements and the amount of care that the patient has already used.	We included similar language in the above paragraph.
Data Validity	Last sentence leaves off with a recommended action but doesn't follow with the GMCB response to the recommendation.	GMCB has implemented some of the recommended changes such as a standard DRG grouping.	Thank you for bringing this to our attention. Could you please provide us with a description and proof of GMCB's response to the VAHHS Payment Variation Report's recommendation to undertake a comprehensive data review?

SAO Request for Further GMCB Information & Responses

The following table outlines the SAO's requests for further information from the GMCB based on the detailed comments in the table above, and the ensuing responses from the board and the SAO.

Report Section	Recommended Change	SAO Request for Information	GMCB response to SAO Request for Further Information	SAO Response
Background	Add as last sentence: VHCURES is representative of over 90 percent of the commercially insured and 100 percent of Vermont residents covered by Medicaid and Medicare.	Thank you for bringing this to our attention. Can the board please provide supporting documentation that "VHCURES is representative of over 90 percent of commercially insured Vermonters?"	We track the estimated VHCURES capture rate for commercial insurance enrollment by comparing and reconciling with other data sources available from the Department of Financial Regulation. These include the Vermont Household Health Insurance Survey (VHHIS) (http://www.dfr.vermont.gov/insurance/health-insurance/vermont-household-health-insurance-survey-vhhis) and the Annual Statement Supplement Report (http://www.dfr.vermont.gov/sites/default/files/ASSR_2012_Market_Share_Report_0.pdf). The ASSR does not capture information on enrollment in self-insured employer plans (110,000) or in Blue Card programs for about 45,000 Vermonters enrolled in Anthem/Wellpoint BCBS plans outside of Vermont. VHCURES does capture the self-insured and Blue Card. The last date for synchronization between VHCURES and these two other data sources was 4th Quarter 2012. VHHIS estimated that total enrollment of Vermonters in both insured and self-insured plans was 355,857 . For the same period, VHCURES included 343,161 average members (total member months divided by 12) for comprehensive major medical enrollment. This represents a 96%	We agree to make this clarification.

			capture but we soften the capture rate to account for exclusion of about 14,000 Vermonters enrolled in Federal Health Benefits Plan not required to file data with GMCB. See APCER_Jul2012_Jun2013_FINAL.xlsx for VHCURES enrollment count for comparable period with other data sources.	
History of VHCURES	Last sentence: During the late 1990s, BISHCA convened a few major insurers on a voluntary basis to develop and test a prototype for a uniform claims reporting system but the effort was short-lived. CMS was not supportive of contributing Medicaid data towards such a state-based effort at this point in time.	Thank you for bringing this to our attention. Could you please provide documentation of this effort?	This period for the proposed voluntary claims data filing by commercial insurers and getting CMS approval for access to Medicaid data was around 1997 or 17 years ago in another department. Participants in these activities included Steve Kappel while employed by BISHCA, Dian Kahn at BISHCA, Josh Slen- state Medicaid Director who is no longer in Vermont, BCBS VT and other major insurers. We also had discussions with some large employers such as IBM regarding acquiring informaton on self-insured Vermonters. Steve and Dian are the institutional memory for this period.	We agree to make this clarification.
History of VHCURES	Rewrite: In 2011, VHCURES expanded to include Medicaid claims. CMS approved an agreement between the Department of Vermont Health Access, which oversees the state's Medicaid program , and BISHCA to incorporate Medicaid data into	We agree to make the clarification, but we need the referenced agreement and the approval from CMS to do so.	See Interagency_MOA_VHCURES_FINAL.doc for the agreement between AHS and BISHCA for inclusion of Medicaid data in VHCURES. AHS legal staff (Susan Harritt) drafted this MOA after approval of CMS Region I Office. Correspondence or any records of discussions between CMS and AHS may be archived by AHS.	We agree to make this clarification.

	VHCURES.			
History of VHCURES	Rewrite: In 2013, CMS granted a separate data use agreement to the board allowing a broader use of Medicare data to support the state's analytical needs related to health care reform. The board was granted the discretion to re-distribute the Medicare data to other Vermont state agencies and state contractors performing work that is directed by the state. The Medicare data are scheduled to be fully integrated and available for release as authorized by the board in April 2014.	We agree to make a clarification to this effect. What entities currently have access to this data? When was Medicare data incorporated into the database?	Under CMS DUA #21696 that licenses the data to GMCB for use restricted to the Blueprint evaluation, only the Blueprint program at DVHA and Onpoint, the Data Custodian and also the DVHA contractor for most of the Blueprint evaluation analytics, have access to the data. Under CMS DUA # 25534 that licenses GMCB for Broad Use and the discretion to re-disclose to other Vermont state agencies and approved state contractors, the data have been re-disclosed to the GMCB analytics contractor Truven Health Analytics to support GMCB contract.	We agree to make this clarification.

Objective 1: Use of VHCURES (Users and Access)	The report should acknowledge the attempt to have a business tool built. More importantly, the sophistication and scope of this data set should be described to put the difficulty of building such a tool in context.	Thank you for bringing this to our attention. Could you please provide documentation of this effort, including any contract for such work and any staff analyses that explain why the tool was lacking? If you cannot provide such information, please provide us with an explanation of this project and where we might find evidence of this effort.	The work that started on development of a BI Tool was to assist VHCURES state agency users to query the data in a business objects environment, format custom reports, and also access a menu of standard reports. The work was discontinued during the delegation of the VHCURES program staff to GMCB prior to the official transfer of authority July 2013. In 2011, Onpoint consulted with BISHCA staff to develop and test an initial specification for a BI query tool and reporting tool. In 2012, Onpoint hosted an interagency training session to test a prototype that included BISHCA, DVHA, VDH, and DMH. The DFR analytics contract under which this work was started was ended shortly after that session (Onpoint contract #18542) and was put out to competitve bid. The contract was awarded to Truven Health for GMCB and did not include BI Tool development. See BI Tool_Proposed Reports.xls.	We agree to note that there was an attempt to build a BI tool.
Users and Access	Rewrite: To date, only one insurer has applied and then withdrew an application for the data. One insurer trade organization was granted access. On the provider side, the Vermont Association of Hospiitals and Health Systems was approved for access as a state contractor on a study. **Northeast Vermont Regional Hospital was**	Neither the board nor DVHA provided any evidence of how NVRH used VHCURES. We have no way to substantiate that NVRH received access to only a subset of the database. Could you please provide documentation to substantiate this claim? Additionally, one board comment in cell E26 of your detailed comments states:	Craig Jones, Director of the Blueprint for Health at DVHA, requested that NVRH have an opportunity to review reporting output from VHCURES quantifying emergency room visits to verify and possibly match up with NVRH's internal data. Blueprint reporting of emergency room utilization indicated some signification variation in the trend for NVRH. Dian Kahn requested that the data reviewer at NVRH, Robert Hersey who was the CFO, file a VHCURES data user affidavit linked with the DVHA DUA as a matter of process. See 2012-09_DVHA_Hersey.pdf. The SAO reference to a grant not to exceed $343,661 for a contract with NVRH must be incorrect and may actually be the DVHA contract	The SAO's Principal Investigator and the GMCB's General Counsel discussed this matter. The SAO provided documentation from the Department of Finance and Management that shows money was paid out under this grant. We are leaving the report language about

	permitted to review a subset of claims data for that NVRH under the DVHA data use agreement.	"For NVRH, there was no payment to them under the DVHA contract." The SAO has a contract with NVRH for a grant not to exceed $343,661. Is the board asserting that the state did not pay NVRH any of that grant amount? Please elaborate on this comment.	with Onpoint for analytics. To our knowledge, the state never paid NVRH anything to review its own data in VHCURES to verify some Blueprint reporting. Craig Jones has more information about the DVHA contract.	NVRH as is because the documentation shows that the report is correct. Any further elaboration on the facts that are presented in this report would need to be substantiated with documented evidence.
Data Validity	GMCB has implemented some of the recommended changes such as a standard DRG grouping.	Thank you for bringing this to our attention. Could you please provide us with a description and proof of GMCB's response to the VAHHS Payment Variation Report's recommendation to undertake a comprehensive data review?	Data review has been an iterative process as experienced users have been testing and the using the data. To date, the most in-depth reviews and analysis of the VHCURES data have been by the Health Care Cost Institute that is using the data in a benchmarking project with GMCB and Truven Health Analytics who is the GMCB analytics contractor. Both of these analytical users have found the data to be usable and actually of adequate quality to support diverse studies and analytics. These researchers and vendors have been able to take extra steps to scrub the data and improve ways to use it. Areas of weakness such as reliance on payer encryption of direct identifiers to generate the unique person identifier are being addressed in proposed rule amendment (collection of direct identifiers for central encryption and identity management) and in the next version of VHCURES that will go out to competitive bid shortly.	We included a sentence to this effect.

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Douglas R. Hoffer
Vermont State Auditor
132 State Street
Montpelier VT 05633-5101

April 18, 2014

Dear Mr. Hoffer:

On March 27, 2014, the Vermont Department of Financial Regulation received a copy of the Vermont State Auditor's draft report, "GREEN MOUNTAIN CARE BOARD—VHCURES: PAST, PRESENT, & FUTURE: Opportunities for Health Care Price Transparency & Greater Consumer Information" ("Auditor's Draft Report"). The Auditor's Draft Report conveyed the results of the Vermont State Auditor's non-audit inquiry into VHCURES. At that time, you welcomed comments from the Department.

After a review of the Auditor's Draft Report, the Department makes the following comments:

- Pages 16-27. The Auditor's Draft Report examines BISHCA Rule H-2007-05. On October 1, 2008, Rule H-2007-05 was promulgated following ordinary rulemaking procedures, including public notice and opportunities for comment and review and approval by the Legislative Committee on Administrative Rules. Since that time, the Department has not received any complaints or inquiries regarding Rule H-2007-05 or the Rule's implementation.
- Pages 3 and 14. Certain references to the Department and its previous name, the "Department of Banking, Insurance, Securities and Health Care Administration" (BISHCA), do not clearly indicate that DFR "replaced" BISHCA. See Act 78 of 2012. BISHCA is not "defunct" (p. 3 of Auditor's Draft Report); BISHCA is now the Department of Financial Regulation (DFR).
- *Passim.* In its discussion of future projects for the Green Mountain Care Board and the State to undertake, the Auditor's Draft Report omits any references to Green Mountain Care, the anticipated universal health care system for Vermonters. See Chapter 18 of Title 33.
- *Passim.* In its discussion of future projects for the Green Mountain Care Board and the State to undertake, the Auditor's Draft Report omits any cost or budget analysis regarding the expense of new programs or revised consumer information programs, nor does the Draft Report include any information regarding the value or proposed enhanced value of its proposed programs to the State or consumers.

Thank you for your consideration of the enclosed comments.

Sincerely,

Susan L. Donegan

Susan L. Donegan
Commissioner, Department of Financial Regulation

CC: David Cassetty, Esq., General Counsel, Department of Financial Regulation
Al Gobeille, Chairman, Green Mountain Care Board

SAO Responses to DFR Comments

The table below outlines the SAO's responses to DFR's comments.

DFR Comment	SAO Response
Pages 16-27. The Auditor's Draft Report examines BISHCA Rule H-2007-05. On October 1, 2008, Rule H-2007-05 was promulgated following ordinary rulemaking procedures, including public notice and opportunities for comment and review and approval by the Legislative Committee on Administrative Rules. Since that time, the Department has not received any complaints or inquiries regarding Rule H- 2007-05 or the Rule's implementation.	That the department has not received any inquiries or complaints about its "health care price and quality transparency rule" is not necessarily an indication of successful implementation. First, the department's only promotion of the program thus far has been to post the rule on a back page of its website. Inquiries and complaints can only come from people who are aware of the rule and who are aware of the information that insurers and providers are supposed to provide. Second, in public view, there is no clear correlation between the implementation of this rule and the rule itself because the consumer information plans that insurers and providers submit to the department are kept confidential. We are not disputing the legal argument for keeping these documents confidential; we are pointing out that it would be very difficult for a Vermont resident to know how an insurer or provider is supposed to respond to this rule. Third, the intent of the rule was "to provide consumers with access to information concerning health care prices, health care quality, and other information necessary to empower consumers." In practice, the program falls short of this goal. We found the information provided through one of the state's main insurers to be of limited utility to a consumer.[1] It did not provide enough information for a consumer to determine what he or she would pay for a service, and it included very little quality information. There is evidence in the consumer information plans and from initiatives across the country that suggests there are opportunities for the state to work closer with insurers and providers to ensure consumers have price and quality information that they can use to make more informed decisions. Furthermore, the department could evaluate the actual systems that insurers and providers create as a result of this rule, in addition to reviewing and approving the consumer information plans submitted to the department. Lastly, the rule was created pursuant to the statute that catalyzed the creation of VHCURES, but the rule was created before VHCURES existed. An update of the rule and the consumer information systems could be considered now that VHCURES has been in existence for five years.
Pages 3 and 14. Certain references to the Department and its previous name, the ''Department of Banking Insurance Securities and Health Care Administration" (BISHCA),	We will use different diction and agree that "defunct" is not an ideal term. We do not fully agree that DFR is a simple replacement of BISHCA. The department was given a new name as the Legislature shifted key resources and health care regulatory authorities to the

[1] See page 21 of the report.

do not clearly indicate that DFR "replaced" BISHCA. See Act 78 of2012. BISHCA is not "defunct" (p. 3 of Auditor's Draft Report); BISHCA is now the Department of Financial Regulation (DFR).	Green Mountain Care Board, including oversight of the hospital budget review process, insurance rate review process, VHCURES, the Vermont Health Care Expenditure Analysis, and so on.
Passim. In its discussion of future projects for the Green Mountain Care Board and the State to undertake the Auditor's Draft Report omits any references to Green Mountain Care, the anticipated universal health care system for Vermonters. See Chapter 18 of Title 33.	We have added the following paragraph to the report addressing this potential development. “Regardless of whether the State implements a publicly financed system, the importance of providing Vermont patients with this information would not be diminished. Moving to such a system may reduce many of the difficulties associated with implementing an accurate price and quality information system. Using VHCURES to fulfill the statutory charges of providing information to consumers and establishing an empowering price and quality information system are important so long as Vermont patients pay different providers different rates for the same services and receive care that varies in quality.”
Passim. In its discussion of future projects for the Green Mountain Care Board and the State to undertake, the Auditor's Draft Report omits any cost or budget analysis regarding the expense of new programs or revised consumer information programs, nor does the Draft Report include any information regarding the value or proposed enhanced value of its proposed programs to the State or consumers.	The Legislature has already determined the value of price and quality information, as illustrated by the goals and charges of 18 V.S.A. §9410. Furthermore, since the Legislature called for a consumer information system, Vermonters have become increasingly responsible for paying a larger share of health care costs. Enrollment in high-deductible health plans has increased substantially in recent years. But while consumers are given a greater incentive to make decisions based on the cost of care, they are not given the information necessary to effectively weigh their options. It is the legal responsibility of the board and the department to provide Vermonters with price and quality information. One of the aims of our inquiry was to assess whether this could be done, and we found strong evidence to suggest that it could – a finding that your department does not dispute. Our report seeks to outline a range of methods that have been employed in other states and which the board and the department could consider to fulfill this statutory requirement. The report also spotlights the costs of a similar initiative that is being implemented by a neighboring state. It is neither the objective of this inquiry nor the responsibility of the Vermont State Auditor’s Office to propose budgets. As the state’s government accountability office, we hope that we have provided you and the board with useful information to help you satisfy this statutory duty.