

All-Payer Claims Database (APCD) Advisory Group - Special Meeting Webinar on Proposed APCD Reports

This will be a webinar for the presentation and discussion of proposed APCD reports, per member agreement at the February 5th meeting.

NOTICE OF MEETING AND AGENDA

Date: **Wednesday, February 18, 2015**

Time: **9:00 a.m. to 11:00 a.m.**

Webinar Link: Click here to join online meeting:
<http://www.mymeetings.com/nc/join.php?sigKey=mymeetings&i=279332022&p=&t=c>

Conference Line: Phone Number: (866) 732-1486
Participant Code: 777801458

Location* Hilton Hartford, Hilton Grand Ballroom West
315 Trumbull Street, Hartford, CT 06103

Directions: <http://www3.hilton.com/en/hotels/connecticut/hilton-hartford-HFDHHE/maps-directions/index.html>

- I. Call to Order and Introductions
 - II. Public Comment
 - III. Approval of February 5, 2015 Meeting Minutes
 - IV. CEO / ED Updates
 - V. Report Development Process
 - VI. Proposed APCD Reporting
 - VII. Next Steps
 - VIII. Future Meetings
 - IX. Adjournment
-

Webinar details available on page 2.

A note regarding attendance:

This meeting will be conducted primarily as a webinar. Member attendance by phone and online is agreeable. Roll call to confirm member attendance will be taken at the start of the meeting.

Webinar Participation Details

I. Conferencing into the meeting:

Phone: (866) 732-1486

Code: 777801458#

II. Joining the Online Webinar:

1. Click the following link to join the webinar now:

<http://www.mymeetings.com/nc/join.php?sigKey=mymeetings&i=279332022&p=&t=c>

2. Enter any required fields.
3. Indicate that you have read the Privacy Policy.
4. Click on Proceed. You will be placed into the webinar at that time.

Webinar Meeting Number: 279332022

Public comment of the agenda is limited to two minutes per person and is not to exceed the first 15 minutes of each meeting. A sign-in sheet will be provided.

Access Health CT is pleased to make reasonable accommodations for members of the public who are disabled and wish to attend the meeting. If special arrangements for the meeting are necessary, please notify Christen Orticari at (860) 241-8444. For further information concerning this meeting, please contact Christen Orticari at (860) 241-8444 or Christen.Orticari@ct.gov.

Meeting materials will become available at: www.ct.gov/hix following each meeting.



All Payer Claims Database Advisory Group Meeting
Draft Meeting Minutes

Date: Thursday, February 5, 2015
Time: 9:00 a.m. – 11:00 a.m. EST
Location: Hilton Hartford Hotel, Hartford Commons Room

Members Present

James Wadleigh (Acting Chair), Tamim Ahmed, Robert Aseltine (phone), Mary Ellen Breault for Thomas Leonardi, David Guttchen for Ben Barnes, Matthew Katz, Mary Alice Lee, Kimberly Martone for Jewel Mullen, Robert Scalettar (phone), Mary Taylor, Victor Villagra (phone), Joshua Wojcik for Kevin Lembo

Members Absent

Roderick Bremby, James Iacobellis, Dean Myshrall for Mark Raymond, Patricia Rehmer, Jean Rexford, Robert Tessier, Victoria Veltri

Other Participants

Robert Blundo, Frank Hoefling, Christen Orticari

I. Call to Order and Introductions

Tamim Ahmed called the meeting to order at 9:00 a.m. Members introduced themselves.

II. Public Comment

There was no public comment.

III. Approval of November 13, 2014 Meeting Minutes

Mary Ellen Breault moved approval of the November 13, 2014 meeting minutes. Kimberly Martone seconded the motion. **Motion passed unanimously without abstention.**

IV. CEO/ ED Updates

Mr. Ahmed reported a brief status update on APCD implementation and accomplishments, including near complete infrastructure development. Agile methodology was applied to make efficient use of development resources and to expedite progress along the nine service lines. Mr. Ahmed introduced Frank Hoefling, a consultant with extensive industry experience in both the IT and health care sector, brought on to help manage APCD implementation.

V. Overview of the APCD Implementation

1. Project Management

Mr. Hoefling discussed the project management disciplines utilized for the APCD project. Mr. Hoefling reviewed project management tools utilized such as a master project plan to comprehensively manage all aspects of the project along their corresponding System Development Lifecycle (SDLC) delivery phases, risk and issues logs, and a change control process were implemented.

Christen Orticari presented an approach to promote advisory member communication throughout the APCD implementation process. AHA planned to send monthly updates with content similar to public meeting presentations. In addition, there were opportunities for feedback. The goal was to consistently bring members up to speed on implementation progress, accomplishments and future objectives to round out the scope of communications.

2. Data Collection - Carriers On-Boarding

Robert Blundo gave an update on the data collection process, timeline, and accomplishments to date. He gave an overview of data submission preparation activities, categorized as communication activities, aimed to make the process as efficient as possible for submitters, or as administrative activities, which were required from a technical policy and process standpoint. Mr. Blundo indicated that online carrier registration for 2015 was being scheduled. He also indicated an outreach campaign was to be formulated for entities not registered in 2014.

3. Data Management Infrastructure

Mr. Blundo provided an update on hardware and software procurement, and APCD infrastructure development progress. Dr. Villagra asked if Access Health Analytics (AHA) received any guidance from the Connecticut State Innovation Model Initiative (SIM), or other entities, regarding their data requirements, and asked if there was a process in place to cross-check its availability. He recommended that AHA maintain a record of data requirements from entities and keep track of data gaps. Mr. Wadleigh asked that the data gap list be added to the list of APCD presentation items for AHCT Board Meetings, and be reported from the Center for Medicare and Medicaid Innovation (CMMI) and SIM perspectives. Mr. Ahmed replied that conversations with SIM were initiated about the availability of APCD data for analysis to support SIM reporting.

Members voiced their concern about the significant portion of the population not able to be captured in the APCD without Medicaid data. Mr. Ahmed informed members that the Department of Social Services (DSS) continued their research for opportunities to provide Medicaid data.

4. Consumer Research & Communication

Mr. Ahmed gave an update on the two focus group sessions moderated by Communicate Health, a health education and communication firm specializing in health literacy improvement and a co-vendor for Onpoint. Focus group research was integral to the design of the website and navigational characteristics. Arrangement of information of the new APCD site needed to be dynamic, easy to use and conform to the way consumers focus on content. Ms. Orticari added that focus group findings at the summary level would be circulated to members.

5. Web Design

Mr. Ahmed informed members that the focus group information was analyzed and reported by Communicate Health. The Atom Group (TAG) and Communicate Health were tasked to collaboratively design the website and TAG was responsible for its build. Dr. Mary Alice Lee asked if other focus groups were planned. Mr. Ahmed replied that additional focus groups were planned to test ease of use on completion of the first website wireframes.

6. Test Environment build for AHCT

Mr. Ahmed described the managed test environment purpose and features, and explained the benefit it may present to stakeholders with interest in APCD reporting capabilities. This was the additional environment, or test platform built to enable greater reporting productivity since the Connecticut APCD may create custom reports within the secured environment.

7. Data Analytics & Reporting

Mr. Ahmed provided an overview of the first 10 proposed reports. Members asked for clarification on who determined the reports, why they were selected, what data and information sources they were based on, and whether additional report opportunities were available for member consideration. Members deliberated report prioritization impact on content given that Medicaid data was not available for the APCD system initial go-live date. Membership had a conversation on report specifications and asked to be more engaged in the report definition and specification process. Mr. Wadleigh asked AHA to create a summary document outlining the selection criteria and rationale, contents, applicable definitions, intended audience, and goal for each of the 10 reports. By February 20, the APCD Advisory Group was to regroup for a discussion on the proposed APCD reports.

VI. Status of Subcommittees

Mr. Ahmed gave an update on the January 8 Privacy and Security Subcommittee meeting. Members discussed the data application and data use agreement constructs, review and release processes and proposed Data Review and Release Committee representation. Feedback from membership was collected following the meeting. Staff continued to work

with Shipman and Goodwin to compose amendments to the Policies and Procedures for data review and release in preparation for proposing it at the next subcommittee meeting on March 18.

Dr. Robert Scalettar announced that Ms. Taylor requested that her position on the Privacy and Security Subcommittee be replaced by her colleague, Tracey Scraba, due to travel constraints. The change was acknowledged by the Subcommittee.

VII. Next Steps

An off-cycle meeting was to be scheduled by February 20 for members to discuss APCD proposed reports.

VIII. Future Meetings

The next regular meeting of the APCD Advisory Group was May 14 from 9:00 to 11:00 a.m. Future meetings were listed on the [APCD webpage](#).

IX. Adjournment

Mr. Ahmed entertained a motion to adjourn the meeting. Ms. Martone motioned. Ms. Taylor seconded the motion. Motion passed unanimously. The meeting was adjourned at 11:00 a.m.

DRAFT



APCD Advisory Group Special Meeting

February 18, 2015

Presentation Overview

- Approval of February 5, 2015 Minutes
- CEO / ED Updates
- Data Analytics & Reporting
- Collaboration Process
- Next Steps
- Future Meetings

CEO / ED Updates

- This is a special meeting to discuss various web reports planned for CT's APCD
- Access Health Analytics (AHA) published a list of 10 (out of total 20) types of reports for planned web publishing over the next 12 months
- Some members expressed concern about the process of selection of the reports
- AHA collected stakeholders' use cases starting around end of 2013
- AHA also interpreted PA 13-247 for strategic directions for the choice of first 10 reports
- AHA created placeholders for 10 reports, defined lightly, for purposes of collecting RFP response
- AHA has also created a document that defines scope, specs and technical parameters, distributed to all Advisory Group members

CEO / ED Updates

- While the selection of the first 10 reports was done more from contractual obligation, some stakeholder inputs and legislative mandate, there is ample opportunity to incorporate robust Advisory Group's recommendations
- While acknowledging our willingness to work collaboratively, there are some challenges in overcoming the following considerations -
 1. Limited Resources - we have budgeted a fixed number of reports and projected resources in producing each one of those
 2. Limited Timeline - contractual obligation to developing these reports within the next 12 months period; payments structured on completed deliveries
 3. Report Contents - each report must be produced from administrative claims data; recognizing limitation of data source is important
 4. Report Complexity - some reports require a lot more time to develop than others; report priorities must take this factor into account
 5. Report Specifications - technical expertise and availability of industry acceptable specifications is required in developing accurate reports

Proposed Reports

The first 10 proposed reports in order of timeline for deliveries -

1. Disease (TBD) prevalence by cities / counties
2. Percent (%) of Population by coverage type (TBD) by cities / counties
3. Utilization of services - specialists' services, diagnostic services, generic vs. brand name drugs - by cities / counties
4. Various population-level reports (TBD) by cities / counties
5. Total Costs of Care profile by cities / counties
6. Costs Transparency for select procedures (TBD) by facilities (inpatient, outpatient and/or stand-alone)
7. 30-day admissions and readmissions by Facilities and/or by conditions (TBD), Preventable 30-day readmissions by Facilities and/or by conditions (TBD)
8. Episode of care for select conditions (TBD) by facilities
9. Density of physicians by specialties (TBD) by cities / counties
10. Costs transparency by provider for various services - office visits, specialists services, treatments

Report Development Process - Background

Legislative & BOD Language/Charge

- Provide health care consumers in the state with information concerning the cost and quality of health care services that allows such consumers to make economically sound and medically appropriate health care decisions; *(P.A. 13-247, S. 144.)*
- The Exchange will make standard, aggregated reports containing information regarding utilization, cost and quality of services available to health care consumers. *(Policies and Procedures: APCD, as adopted by the Board of Directors on December 5, 2013)*

Statement of Work

- The Contractor successfully completes and delivers an additional 10 written reports to be determined by AHA
- "The Contractor successfully creates the following reports from previous slide...."

Report Development Process - Landscape

APCD Report Stakeholders

Policy Makers

Consumers

Providers

Health Plans

Stakeholder Report Tools/Options

Public Reports

Data Requests

Reporting Services

- Ad-Hoc Requests
- Reoccurring Requests

Development/
Testing
Effort

Stakeholder
Input

Report Development Process - Challenges/Opportunities

Challenges

- Report Prioritization & Development Timeline Determination
- Ensuring Accurate & Actionable Information
- Collecting and Utilizing Actionable Stakeholder Feedback While Maintaining Momentum
- Ensure Privacy and Competition Remain Intact
- Acknowledge Contractual Limitations

Opportunities

- Create a Connecticut specific platform to drive improvement and transparency
- Utilize input/guidance provided from community stakeholders
- Meet/Exceed legislative goal and intention
- Utilize results as a platform for future improvement

Report Development Process – Mission/Vision

Mission:

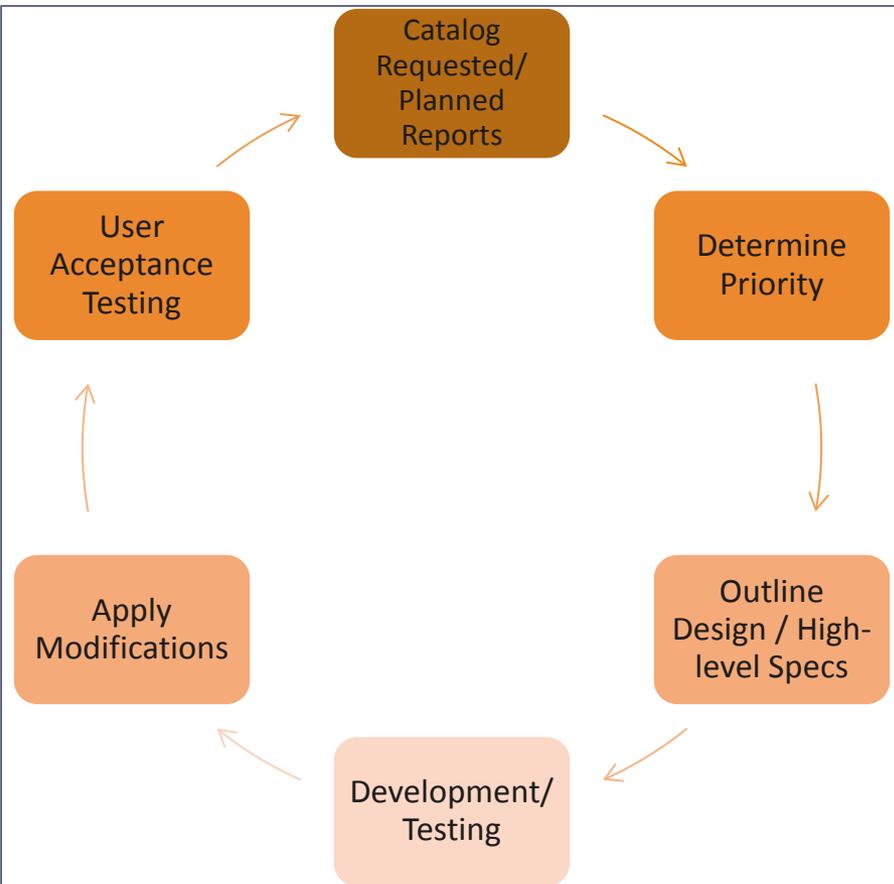
To create public reports which are actionable, accurate, and attainable in order to improve population health, enhance outcomes, and/ or reduce cost of care

Vision:

- Create a development process through which stakeholders' expectations, expertise and feedback is effectively and efficiently included
- Employ a practical development timeline, which effectively incorporates identified report prioritization and recognizes available resources
- Ensure resources are utilized efficiently to maximize benefit and efficacy to users
- Establish protocol through which report specifications can be effectively communicated

Report Development Process - Outline

Report Development Cycle



1) Catalog Requested Reports:

- Generate a list of requested/planned reports
- Identify at a minimum:
 - Report Purpose/Goal
 - Intended Audience
 - Measurement Strategy
 - Estimated Level of Effort
 - Examples/Citations of existing work

2) Determine Priority:

- Propose Report Development Timeline & Report Inclusion/Exclusion Plan

3) Outline High-level Specs / Design:

- Report Development Strategy
- Benchmarks / Standards / Guidelines to be used
- Q&A

4) Development / Testing:

5) Apply Modifications:

6) User Acceptance Testing

- “No Surprises” stakeholder approach

Report Development Process – Catalog Example

1) Catalog Requested Reports:

- Example – Disease Prevalence Report
- Identify at a minimum:
 - Report Purpose/Goal – Create disease prevalence report by geographical units and by age/sex bands for determining distribution of diseases in CT.
 - Intended Audience – Primarily policymakers, researchers & academics, and providers focused on state of public health in CT.
 - Measurement Strategy – Well validated identification protocols from NCQA, CMS or similar respectable entity.
 - Estimated Level of Effort – Low.
 - Examples/Citations of existing work – See Colorado's disease prevalence reports. (<https://www.comedprice.org/#/map>)

Report Development Process - Feedback/Discussion

Placeholder for Advisory Group Discussion & Feedback

Next Steps

Future Meetings

Access Health Analytics

All Payer Claims Database - 2015 Meetings Schedule

All meetings are held on the second Thursday of each month from 9:00 - 11:00 a.m. EST.
(unless otherwise indicated)

*Session - indicates that the meeting will not be held at the LOB due to Legislative Session.

Date	Venue	Venue
February 18, 2015 [^]	9:00 - 11:00 AM	Htfd. Hilton
May 14, 2015	9:00 - 11:00 AM	Htfd. Hilton
August 13, 2015	9:00 - 11:00 AM	LOB
November 12, 2015	9:00 - 11:00 AM	LOB

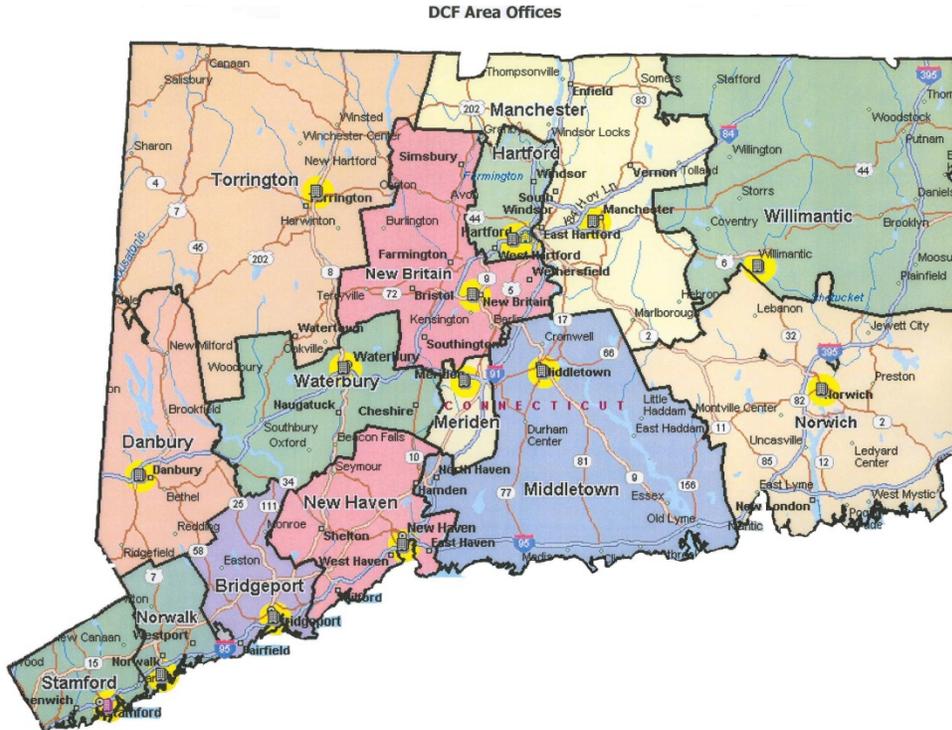
[^] Special Meeting

Samples of Potential Reports and Designs for APCD's Self-Serving Web Reporting

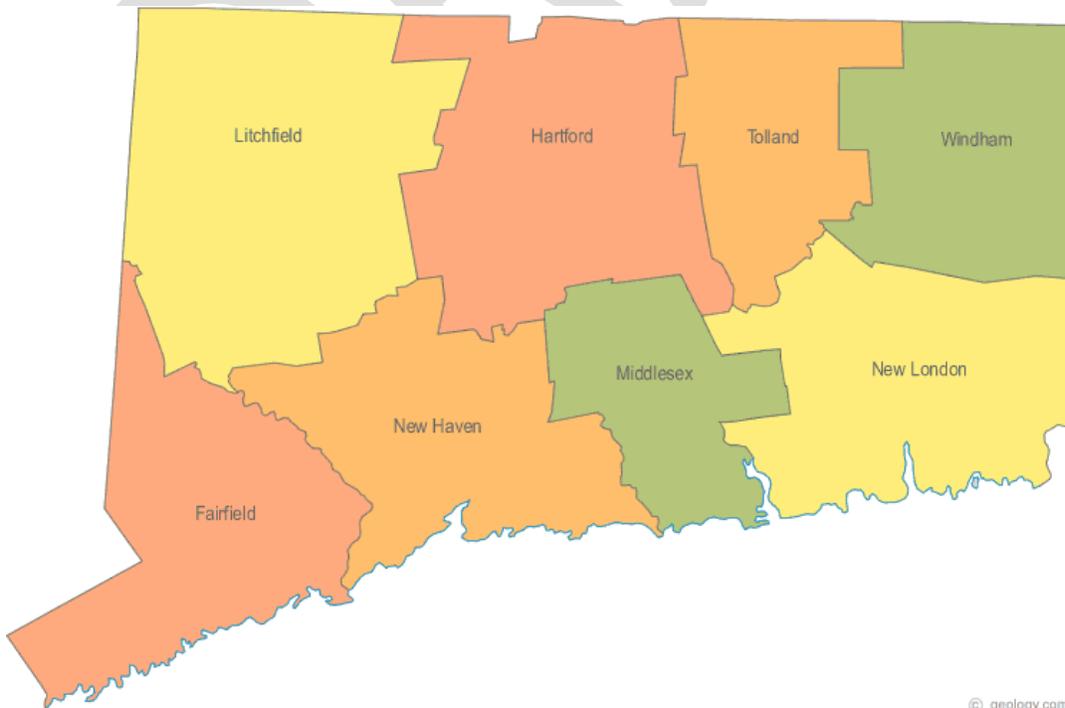
Created by:
Tamim Ahmed
February 17, 2015

Visualization of Map Types:

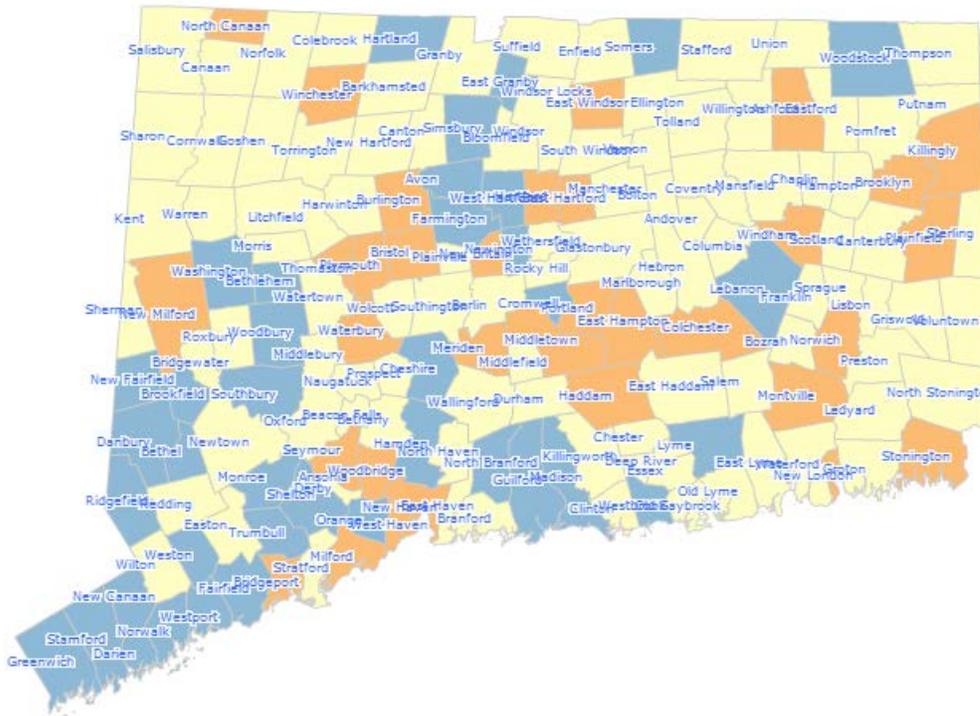
Main Town/City Based Map



County Based Map



Town Based Map



Web reports are highly visual. Connecticut is a small state. We are struggling to create visual presentation by geographical units. Above, as potential geographical units I have presented 3 options –

1. Using DCF areas definition as such geographic units
2. Using current County map definition for geographic units
3. Using current towns as geographic units but it will certainly violate HIPAA restrictions as not meeting 20,000 eligible members to start with
4. Not shown, but can be considered, is the large metropolitan city and its adjacent areas as part of it. Will need some work to define the associated areas to a large city say Hartford. For example, would we consider New Britain as part of Hartford metropolis? How can we determine such associations across all the town in CT to large cities?

Report 1: Disease prevalence by cities / counties

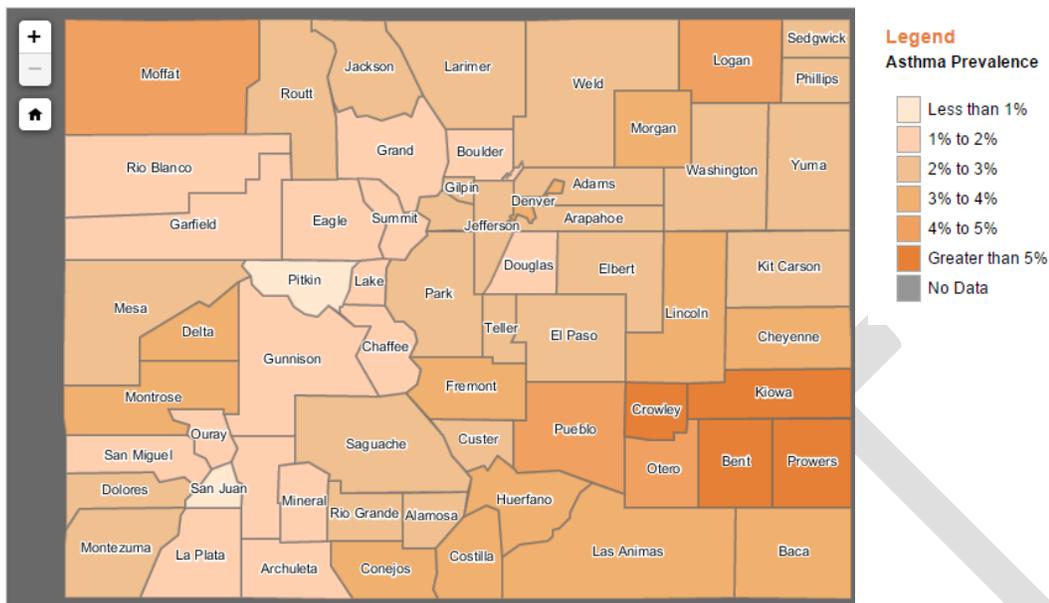
Objective: This report will show prevalence rates of various diseases based on claims data. We intend to use 2-year worth of claims data to create list of people with select conditions. The criteria for selection must be based on credible sources – NCQA (National Committee for Quality Assurance), CMS (Center for Medicare & Medicaid Services), etc. The web view will allow a user to create prevalence report by various class variables – disease, payers (e.g., commercial, Medicare or Medicaid in future), geographic entity (e.g., county, city or some other acceptable units), age and sex bands, etc. Onpoint has a list of diseases with solid identification algorithms. We also have collected the additional inventory list from which we can select additional 5-7. Please propose those additional disease states. Due to capacity/resource constraint, we can only accommodate ≈20 diseases for reporting. Earlier (in my email) I mentioned that the criteria for selecting diseases should be the following:

1. Highly prevalent disease/condition, especially for <65 population
2. Diseases/conditions that affect various age groups or gender differently, e.g., <18 versus other age groups, gender, etc.
3. More focus on chronic diseases/conditions
4. Diseases/conditions where preventative care is effective
5. Claims data used will be from commercial population so diseases prevalent in Medicare population will not be appropriately represented

Proposed Diseases for Inclusion:

Onpoint's List - ADHD, Asthma, Breast Cancer, Cervical Cancer, CHF, Colorectal Cancer, COPD, Coronary Artery Disease, Depression, Diabetes, Hypertension, Lung Cancer, Stroke

Inventory List - Atrial Fibrillation, Acute Myocardial Infarction, Anemia, Alzheimer's Disease (related disorder or Senile Dementia), Chronic Kidney Disease, Endometrial Cancer, Glaucoma, Hip / Pelvic Fracture, Hyperlipidemia, Ischemic Heart Disease, Osteoporosis, Prostate Cancer, Rheumatoid Arthritis / Osteoarthritis



(Source: <https://www.comedprice.org/#/map>)

OUTCOME VARIABLES

1. Counts and % of eligible population

CLASS VARIABLES

1. Diseases – expecting 10-15 diseases
2. Payers – Commercial (for future - Medicaid, Medicare payers)
3. County/City – TBD at what geographic level
4. Age bands
5. Gender

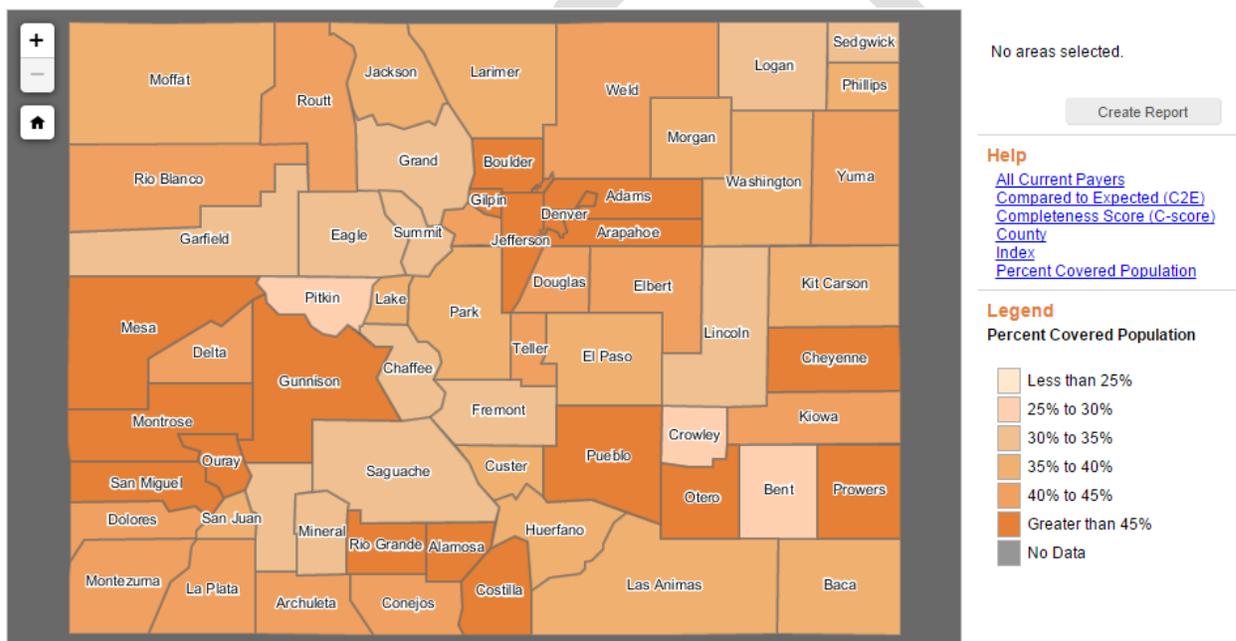
Comments/Inputs for Report # 1

1. Disease List:
2. County/City level of aggregation:
3. Age Bands: suggest some (e.g., age in years <18, 18-34, 35-44, 45-65)
4. Others?
5. Priority: should it be listed as #1 report?

Report 2: Percent (%) of Population by coverage type by cities / counties

Objective: *Percent population covered* represents the percentage of the total population for an area that is currently included in the APCD. The percentage is calculated based on the number of unique lives in the APCD by ZIP code compared to the total population in that ZIP code (CT's DPH has such information from Census data available online).

This report will display various characteristics of the reported population from eligibility perspective. Although we intend to capture three outcomes in this report – counts, medical deductible and premium – only data completeness will allow us to report on all three. The class variables will allow us to slice and dice this population in various attributes – payers, geographical entity, type of plans, age/sex bands, coverage level code, marital status, family size, and employee type. We'll also include race/ethnicity for reporting if data is found to be reasonably complete.



Source: <https://www.comedprice.org/#/consumer>

Outcome Variables

1. Counts
2. Medical Deductible levels
3. Premium

CLASS VARIABLES

- Payers – Commercial (for future - Medicaid, Medicare payers)
- County/City – TBD at what geographic level
- Age/Sex bands
- Types of plans – HMO, PPO, POS, Indemnity

- Coverage level code – Family, Employee & Spouse, etc.
- Marital Status
- Family size
- Employee type
- Race/Ethnicity

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Comments/Inputs for Report # 2

1. Report will show counts, premium and deductible levels (if data is accurate on the last two outcomes)
2. County/City level of aggregation: suggest county level due to huge swings of utilization and costs in small population, particularly if done on town basis.
3. Age Bands: suggest some (e.g., age in years <18, 18-34, 35-44, 45-65)
4. Commercial plan types: Is the suggested plan types informative?
5. Coverage levels & family size: what type of plans are popular? Family, Single coverage, dual coverage, etc.
6. Marital Status: is this an important variable to track?
7. Employee Types: we'll report how good data we are getting. Values will be (a) hourly, (b) seasonal, (c) salaried, and (d) temporary.
8. Priority: should it be listed as #2 Report?

Report 3: Utilization of services – specialists’ services, diagnostic services, generic vs. brand name drugs – by cities / counties

Objective: This report will show utilization of health care services by various sub-populations’ attributes. Users will be able to understand how utilization of various types varies by geography, type of health plans (e.g., HMO, PPO, POS, Indemnity, etc.), age/sex bands and by payers (for future when Medicaid and Medicare will be brought in). This report will provide utilization measures which allows for direct comparisons. Utilization measures are stated in ‘rate per 1,000 eligible members per year’.

The outcome variables are encounters and rates. Encounters are just counting how many inpatient admissions have taken place, how many outpatient services have been offered, office visits made, etc. Rates will be created by dividing the encounters with eligible population to normalize the outcomes. So if a particular combination of class variables creates unequal eligible population, rates will be normalized to reflect true utilization pattern.

Outcome variables such as encounters, admissions, rates, will be created by list of utilization categories. For example, inpatient care can be divided up into two or four or six categories. We’ll have to look into the data to determine what would be appropriate and meaningful. For example, inpatient admissions (IP) can be broken up into IP-Acute, IP-Observations, IP-Obstetrics, IP-SNF, IP-Longterm, etc. We’ll have to determine what would be the right level for the utilization buckets.

An example of a report is provided below. The report shows overall level of utilization between various utilization buckets between counties, and also utilization by age/gender characteristics.

There are a few metrics created in the report.

- 1. Illness Burden** – Using 3M’s proprietary software, we intend to develop illness burden of a population. For each Age/Gender/CRG combination, claims data is used to provide cost and utilization information and a “weighting system” is developed to identify the relative health care resource usage for a specific type of patient. This weight information is then aggregated to identify the illness burden for any given population. The associated illness burden of a population can help identify expected costs for a population.

By understanding a “typical” or expected cost for a certain patient population, actual patient service usage and costs can provide more meaningful comparisons. The average illness burden score across the entire population in the database is represented as 1.0. A number that is below 1.0 indicates that the population is relatively healthier and/or utilizes less health services than the state average. For example, a county with an illness burden score of 0.87 means that the population of that county is healthier and/or doesn’t use as many services compared to the rest of the population of Connecticut’s commercial population represented in the database.

- 2. Compared to Expected (C2E)** - Compared to Expected (C2E) numbers allow comparisons of costs and/or use of services with what is typical or “expected” for a particular population. On the cost side, the expected price is determined by averaging typical costs for patients in the same Clinical Risk Group (CRG), and age and gender categories. Once this is established, each de-identified person is assigned an “expected cost”. Expected costs for a group are calculated by adding together the expected costs

for each de-identified person assigned to that group. Actual costs are determined by adding together the payments received for services associated with those same people. If the actual dollars exceed the expected dollars, the resulting “C2E” value is a “positive” percentage. If the C2E value is greater than 25%, it is displayed as a red number. Conversely, if actual expenditures fall below expected results, the number is a “negative” percentage and will be displayed as a green number if the C2E is below -25%. Similar calculations are applied to report service usage instead of costs.

- 3. Completeness Score** – this accounts for how complete a payer’s population count we may have collected via APCD. If commercial data is collected, we want to estimate what proportion of commercial data is collected for a given population – 25% or less, 25-50%, 51-75% or 76-100%. The more the completeness the higher the confidence as represented by values C1 through C4, with C4 being the highest confidence assigned due to more completeness of data for reporting.

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This report will provide use of health services, or called utilization report. I have taken a sample from Colorado's APCD below. We can create such report by counties, age/sex bands and plan types.

	Adams		Alamosa		Arapahoe		State
Completeness Score	C3		C2		C3		C2
Illness Burden Score	0.77		0.88		0.81		0.78
	Rate Per Thousand	C2E Rate	Rate Per Thousand	C2E Rate	Rate Per Thousand	C2E Rate	Rate Per Thousand
Utilization Per Thousand Per Year							
Hospital Admissions	40	-10%	37	-10%	36	-14%	33
Outpatient Visits	456	-46%	1,376	65%	374	-57%	523
ER Visits (subset of Outpatient Visits)	116	-46%	114	-48%	102	-54%	98
Professional Claims	5,652	18%	5,029	-6%	5,886	17%	5,357
Ancillary Claims	453	-20%	594	-2%	489	-16%	491
Rx Scripts	6,398	-19%	5,280	-36%	6,629	-19%	6,362
% Generic	87%	7%	83%	1%	85%	4%	83%
Hospital Admissions by Gender/Age Per Thousand Per Year							
Female	52	-14%	59	-1%	45	-18%	42
1 - Child (0-17)	38	-12%	6	-49%	33	-23%	28
2 - Young adult (18 - 34)	81	-23%	111	-7%	63	-26%	64
3 - Mature adult (35 - 64)	44	-4%	53	14%	41	-10%	37
Male	27	0%	14	-36%	26	-5%	23
1 - Child (0-17)	38	-17%	6	-41%	37	-17%	30
2 - Young adult (18 - 34)	10	23%	5	-62%	10	-6%	9
3 - Mature adult (35 - 64)	30	12%	22	-30%	29	5%	28
Outpatient Visits by Gender/Age Per Thousand Per Year							
Female	548	-46%	1,849	80%	425	-58%	616
1 - Child (0-17)	367	-76%	598	-61%	310	-82%	351
2 - Young adult (18 - 34)	410	-63%	1,581	38%	349	-66%	461
3 - Mature adult (35 - 64)	705	0%	2,516	234%	513	-28%	801
Male	358	-46%	890	40%	318	-55%	425
1 - Child (0-17)	396	-76%	602	-59%	346	-80%	401
2 - Young adult (18 - 34)	174	-38%	430	28%	197	-40%	258
3 - Mature adult (35 - 64)	436	31%	1,261	215%	369	5%	522
ER Visits by Gender/Age Per Thousand Per Year							
Female	131	-50%	121	-54%	113	-57%	105
1 - Child (0-17)	136	-62%	114	-69%	97	-75%	102
2 - Young adult (18 - 34)	159	-59%	130	-66%	150	-61%	133
3 - Mature adult (35 - 64)	113	-26%	119	-26%	102	-33%	93
Male	101	-40%	107	-37%	90	-49%	90
1 - Child (0-17)	154	-60%	101	-74%	112	-72%	121
2 - Young adult (18 - 34)	91	-28%	69	-50%	99	-29%	93
3 - Mature adult (35 - 64)	79	5%	129	48%	75	-5%	73

Source: <https://www.comedprice.org/view/reports/pdf.aspx>

OUTCOME VARIABLES

1. Service counts by various types of utilization categories
2. Service utilization rates, e.g., per 1,000 members per year

CLASS VARIABLES

1. Utilization categories – Hospital, Outpatient, Professional, Ancillary, Pharmacy
2. Payers – Commercial (for future - Medicaid, Medicare payers)
3. County/City – TBD at what geographic level
4. Age/Sex bands
5. Types of plans – HMO, PPO, POS, Indemnity

DRAFT

Comments/Inputs for Report # 3

1. Utilization buckets – appropriate?
2. County/City level of aggregation: suggest county level due to huge swings of utilization and costs in small population, particularly if done on town basis.
3. Age Bands: suggest some (e.g., age in years <18, 18-34, 35-44, 45-65)
4. Commercial plan types: Is the suggested plan types informative?
5. Priority: should it be listed as #3 Report?

Report 4: Population Level Report - Illness Burden Report (TBD) by cities / counties

Objective: The *Illness Burden for a population* is a number used to measure the relative health of that group based upon the number and types of healthcare services used. A higher number indicates that population uses more and/or costlier services and is typical when a greater portion of the group has chronic disease. Likewise, smaller numbers (those below 1.0 - the average), indicate a healthier population using less services.

Using 3M's proprietary software, we intend to develop illness burden of a population. For each Age/Gender/CRG combination, claims data is used to provide cost and utilization information and a "weighting system" is developed to identify the relative health care resource usage for a specific type of patient. This weight information is then aggregated to identify the illness burden for any given population. The associated illness burden of a population can help identify expected costs for a population.

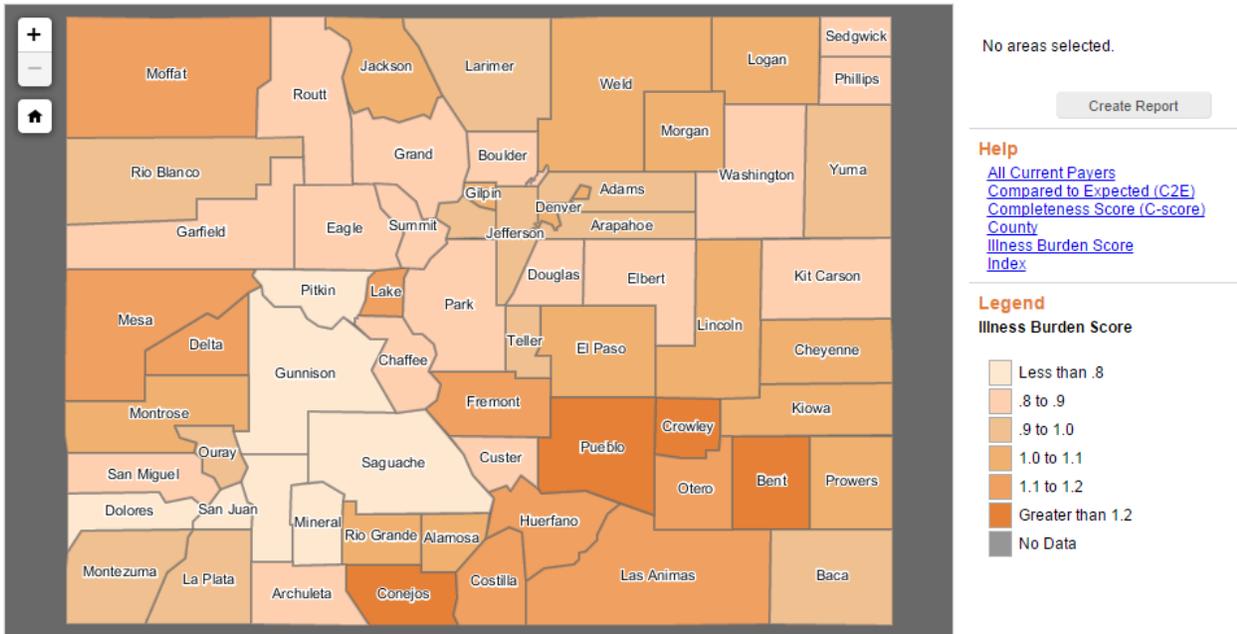
By understanding a "typical" or expected cost for a certain patient population, actual patient service usage and costs can provide more meaningful comparisons. The average illness burden score across the entire population in the database is represented as 1.0. A number that is below 1.0 indicates that the population is relatively healthier and/or utilizes less health services than the state average. For example, a county with an illness burden score of 0.87 means that the population of that county is healthier and/or doesn't use as many services compared to the rest of the population of Connecticut's commercial population represented in the database.

Patient Segments - Patient Segments are used to communicate the health status of a population. Where the CRG system outlined above produces precise classifications based upon granular disease differentiation, it is difficult to report and communicate the information across the more than 1,000 categories of health status. Patient segments provide a higher level view while retaining common health conditions for reporting purposes. The descriptions of each category can be found below.

- Non-User - An individual with enrollment in some insurance system in the APCD that has not filed any medical claims during the calendar year.
- Healthy – No health issues, or minor illnesses with low use of services including primarily prevention, well care, and minor acute care services.
- Stable - Low illness burden with modest use of services including well care and occasional acute care service.
- At-risk - Modest illness burden with clear potential for deterioration, increasing inconsistent use of well care, specialty and acute care services.
- Simple Chronic - Medium illness burden with consistent use of services to treat a chronic condition.
- Complex Chronic - Medium to high illness burden with, consistent use of services to treat severe or multiple chronic conditions.
- Critical - High illness burden with consistent use of services for life threatening illness.

Completeness Score (see earlier definition on page 8)

Illness Burden (see earlier definition on page 7)



Source: <https://www.comedprice.org/#/consumer>

	Adams		Alamosa		Arapahoe		State
Completeness Score	C3		C2		C3		C2
Illness Burden Score	0.98		1.07		0.99		1.00
	% Population	Index	% Population	Index	% Population	Index	% Population
▼ Patient Segments							
Non User	26%	1.02	18%	0.69	27%	1.05	26%
Healthy	45%	1.03	50%	1.15	42%	0.96	43%
Stable	6%	1.01	8%	1.44	5%	0.95	6%
At Risk	9%	0.88	10%	0.92	10%	1.01	10%
Simple Chronic	9%	0.93	9%	0.93	10%	1.05	9%
Complex Chronic	5%	0.95	6%	1.13	5%	1.00	5%
Critical	0%	0.87	0%	0.59	1%	1.01	1%

OUTCOME VARIABLES

1. Counts and % of people with various patient segments
2. Illness burden score

CLASS VARIABLES

1. Payers – Commercial (for future - Medicaid, Medicare payers)
2. County/City – TBD at what geographic level
3. Age/Sex bands
4. Types of plans – HMO, PPO, POS, Indemnity

Comments/Inputs for Report # 4

1. Patient segments derived from 3M software – clinical grouper
2. County/City level of aggregation: suggest county level due to huge swings of utilization and costs in small population, particularly if done on town basis.
3. Age Bands: suggest some (e.g., age in years <18, 18-34, 35-44, 45-65)
4. Commercial plan types: Is the suggested plan types informative?
5. Priority: should it be listed as #4 Report?

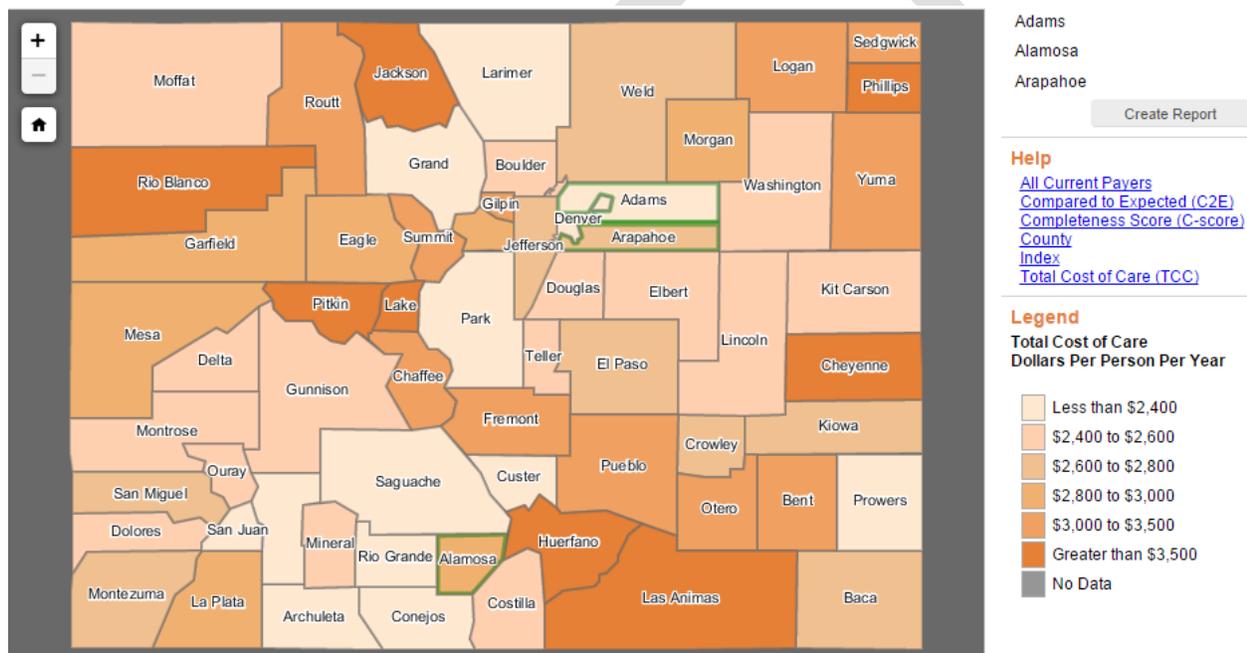
Report 5: Total Costs of Care profile by cities / counties

Objective: The **Total Cost of Care** report represents the total dollars paid for all health care services received by an individual such as hospital, clinic, physician visits, and prescription costs. Amounts paid by both the insurer and by the individual in the form of copays, deductibles and other cost sharing mechanisms are included. The results are displayed as total dollars per person for the year. The rate represents the population living in that geography, not where the services were received.

This report will be similar in structure to Report 2. The only difference will be it will have dollars/costs reported within the similar utilization bucket structure (as in Report 2). Again, the dollars will be adjusted for **illness burden and compared to expected costs**.

Completeness Score (see earlier definition on page 8)

Illness Burden (see earlier definition on page 7)



Source: <https://www.comedprice.org/#/map>

This report's objective is to show total costs of care. The report version is on the next page.

	Adams		Alamosa		Arapahoe		State
Completeness Score	C3		C2		C3		C2
Illness Burden Score	0.98		1.07		0.99		1.00
	Actual	C2E Dollars	Actual	C2E Dollars	Actual	C2E Dollars	Actual
Dollars Paid Per Person Per Year							
Total Cost of Care	\$2,384	-8%	\$2,805	7%	\$2,634	-6%	\$2,487
Inpatient Facility Cost	\$498	-1%	\$596	36%	\$494	-4%	\$490
Outpatient Facility Cost	\$620	-11%	\$700	2%	\$610	-17%	\$635
ER Facility Cost (subset of Outpatient Cost)	\$171	8%	\$127	-29%	\$175	10%	\$137
Professional Cost	\$736	-10%	\$894	3%	\$868	1%	\$758
Ancillary Cost	\$93	-15%	\$122	7%	\$116	-2%	\$101
Rx Cost	\$437	-13%	\$493	-7%	\$546	-7%	\$503
% Generic	#	-	#	-	#	-	#
Dollars Paid Per Person Per Year by Gender/Age							
Female	\$2,537	-10%	\$2,952	0%	\$2,778	-8%	\$2,630
1 - Child (0-17)	\$1,389	-19%	\$1,788	-2%	\$1,467	-21%	\$1,289
2 - Young adult (18 - 34)	\$3,165	-9%	\$3,111	-5%	\$3,110	-5%	\$2,874
3 - Mature adult (35 - 64)	\$4,715	-4%	\$5,039	6%	\$4,496	-3%	\$4,438
Male	\$2,205	-6%	\$2,629	17%	\$2,463	-3%	\$2,323
1 - Child (0-17)	\$1,626	-19%	\$1,373	-21%	\$1,687	-22%	\$1,507
2 - Young adult (18 - 34)	\$2,246	-2%	\$2,488	11%	\$2,766	10%	\$2,318
3 - Mature adult (35 - 64)	\$4,137	17%	\$5,824	65%	\$3,869	17%	\$3,887

Source: <https://www.comedprice.org/#/reports>

OUTCOME VARIABLES

1. Utilization categories – Hospital, Outpatient, Professional, Ancillary, Pharmacy
2. Includes all financial measures – allowed, paid, out-of-pocket costs
3. Counts of patients
4. Illness burden score

CLASS VARIABLES

1. Payers – Commercial (for future - Medicaid, Medicare payers)
2. County/City – TBD at what geographic level
3. Age/Sex bands
4. Types of plans – HMO, PPO, POS, Indemnity

Comments/Inputs for Report # 5

1. County/City level of aggregation: suggest county level due to huge swings of utilization and costs in small population, particularly if done on town basis.
2. Age Bands: suggest some (e.g., age in years <18, 18-34, 35-44, 45-65)
3. Commercial plan types: Is the suggested plan types informative?
4. Priority: should it be listed as #5 Report?

Report 6: Costs Transparency for select procedures (TBD) by facilities (inpatient, outpatient and/or stand-alone)

Objective: The objective of this report is to create price transparency information for consumers. Price transparency means that patients or consumers will know the approximate cost of health care services before they receive care. This will allow a consumer to use web-based browsing tools at Connecticut's APCD site to input some information regarding location, plan deductible/coinsurance and type of surgeries to get all types of financial information which will help the consumer to choose a physician to get the service from. Since this is going to be based on anonymous browsing, we would not be able to estimate deductible (i.e., out-of-pocket costs) accurately. But if the consumer correctly inputs plan-benefit deductibles/coinsurance, it may be possible to create a good estimate of out-of-pocket costs for the consumer.

Selections:

1. Procedure List - We can have a set of procedures from which to select one of interest. This list will go through a lot of analyses before finalizing it. We do not have a preliminary list yet.
2. Distance – this will be a selection item.
3. Insurance Carrier – may not be possible because of existing anti-trust regulations.
4. Plan Type – this is possible and will help in making the rates more accurate.
5. Deductible levels – will have to see how we can get the consumer to input this accurately. Because this will enable him/her to get correct estimates of what the consumer will pay out-of-pocket versus what the insurance carrier will pay.
6. Costs of surgeries based on average or median distribution.
7. Define costs of surgery in totality – not just the procedure itself, but all ancillary and professional costs associated with it.

Quality Transparency:

It is known that consumers prefer to have quality attributes of their physicians in making appropriate choice along with price comparisons. We need to do the following:

1. We need to create some quality markers for procedures/surgeries from claims data.
2. We can also indicate how many procedures that a given facility has done, an indirect way of indicating that volume of services equate to higher proficiency and thus fewer complications.

New Hampshire's Price Transparency Tool

MRI - Brain (outpatient)

Postal code

Distance

- Entire State
- 10 Miles
- 20 Miles
- 50 Miles
- 100 Miles
- 250 Miles

Enter your zip code and select the Radius from which you want to view selected hospitals and other medical facilities.

Select your insurance carrier

- Anthem - NH
- CIGNA
- Harvard Pilgrim HC
- Other Insurance

Select your insurance plan type

- Health Maintenance Organization (HMO)
- Other Insurance Plans

Enter your level of benefit deductible: *

\$ 1000 .00

Deductible amounts refer to individual coverage, not family coverage. If the plan has more than one deductible, use the highest level to determine the appropriate policy type.

Detailed estimates for Insured Procedure

Procedure: MRI - Brain (outpatient)

Procedure Description: Magnetic resonance imaging of the brain, without and then with contrast material.

Procedure Code: 70553

Insurance Plan: Anthem - NH - Health Maintenance Organization (HMO)

Within: 1000 Miles of Concord, NH (03301)

No postal code entered. Showing results for entire state.

Lead Provider	Estimate of What you Will Pay	Estimate of What Insurance Will Pay	Estimate of Combined Payments	Precision of the Cost Estimate	Typical Patient Complexity
AMERICAN MEDICAL IMAGING ☎ 603.766.6736	\$1,058	\$6	\$1,064	HIGH	MEDIUM
CONCORD IMAGING CENTER	\$1,429	\$48	\$1,477	HIGH	MEDIUM
PARKLAND MEDICAL CENTER ☎ 603.432.1500	\$1,612	\$68	\$1,680	VERY LOW	HIGH
DERRY IMAGING CENTER	\$1,673	\$75	\$1,748	MEDIUM	MEDIUM
DARTMOUTH-HITCHCOCK CLINIC	\$1,696	\$77	\$1,773	HIGH	MEDIUM
PORTSMOUTH REGIONAL HOSPITAL ☎ 603.436.5110	\$1,752	\$83	\$1,835	MEDIUM	MEDIUM
CATHOLIC MEDICAL CENTER ☎ 603.668.3545	\$2,237	\$137	\$2,374	VERY LOW	MEDIUM

Source:

http://nhhealthcost.nh.gov/insured/results?procedure_id=18&zip%5Bpostal_code%5D=&zip%5Bsearch_distance%5D=1000&zip%5Bsearch_units%5D=mile&carrier_id=1&plan_type=1&deductible=1000&coinsurance=90

Outcome Variables

1. Name of facility
2. Costs – average or median pay amounts for consumer and carrier
3. Costs for professional, ancillary and facility for the procedure
4. Distance to facility
5. Number of surgeries performed

CLASS VARIABLES

1. Payers – Commercial (for future - Medicaid, Medicare payers)
2. Types of procedures/surgeries - TBD
3. Radius of Search – typically in miles
4. Types of plans – HMO, PPO, POS, Indemnity

Comments/Inputs for Report # 6

1. Report will show costs paid by insurance companies and the portion owed by the patient; however without knowing exact plan-benefit design it will be difficult to create accurate patients' share of costs
2. We'll select a set of procedures which can be performed in hospital, hospital outpatient or other standalone surgical centers. Both will be developed by looking at procedures which are done on a single day in any of the three places or on non-inpatient basis.
3. We'll let the user input zip codes to perform the search for a choice of variable radius in miles
4. Commercial plan types: inclusion of this information will narrow the level of accuracy for patients' out-of-pocket costs
5. Priority: should it be listed as #6 Report?

Report 7: 30-day readmissions by Facilities and/or by conditions (TBD), Preventable 30-day readmissions by Facilities and/or by conditions (TBD)/Regions

Objective: The intent of these reports is to show readmissions as within 30 day upon discharge. Readmission is supposed to be an indicator of lower quality service and/or suboptimal care, unless the readmission was planned. Preventable readmission adjusts for it.

30 Day All Cause Readmissions This metric represents the number of hospital readmissions per admission, regardless of cause, that occur within 30 days of hospital discharge. The readmission rate is displayed as total 30-day readmissions over total admissions. Each admission, including readmissions, restarts the 30 day window for calculating readmissions.

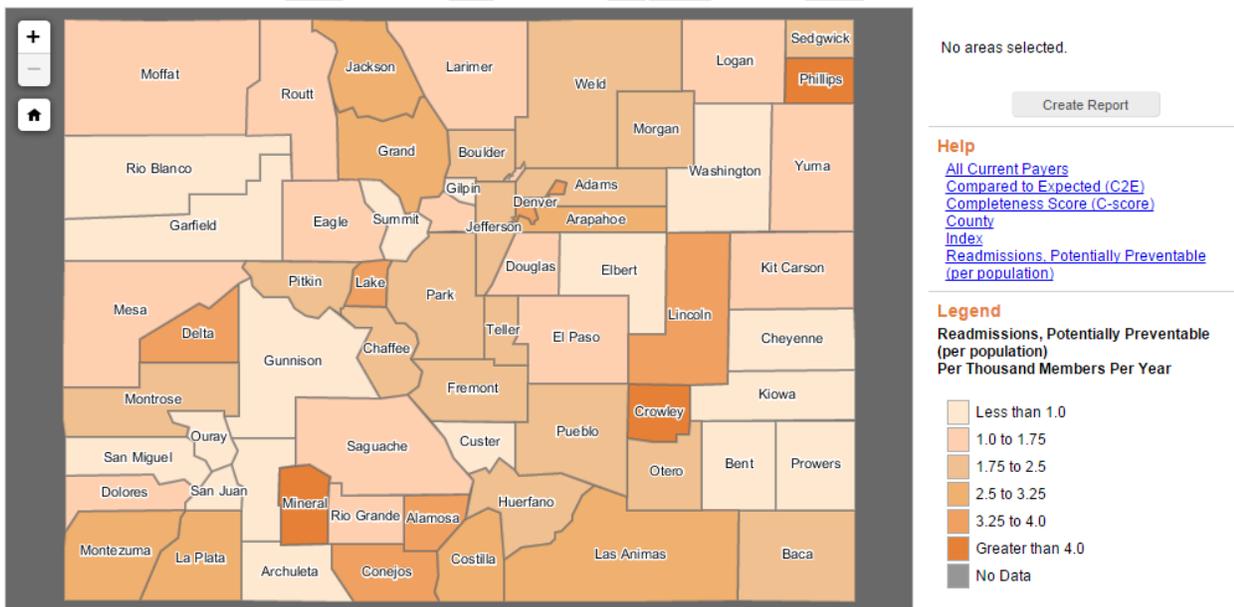
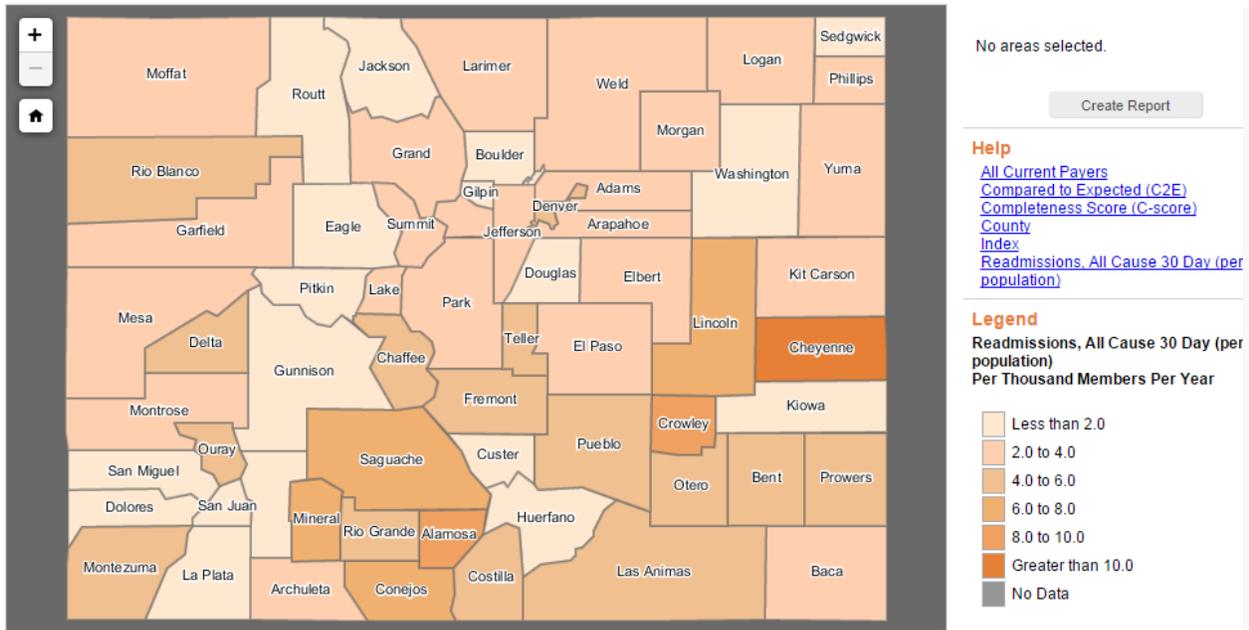
Preventable 30 Day Readmissions This metric identifies the percentage of inpatient claims that result in an associated readmission within 30 days (as defined by 3M's Potentially Preventable Readmission). This information provides insight on how to pinpoint potential opportunity in reducing readmissions and improving the overall quality delivery of healthcare.

Service Lines - These two types of metrics/outcomes will be created at facility level and other class variable level. In Connecticut, there are 31 hospitals. This report will be based on hospital records. The types of readmissions will be determined via 3M's Inpatient Service Lines. **Inpatient Service Lines** are groupings based on the primary reason for a patient's stay at a hospital. Service lines correspond with the hospital department responsible for providing care. 3M™ APR (All Patient Refined) DRG Software is used to determine service lines which include:

1. Behavioral Health
2. Cardiology
3. Gastroenterology
4. General Surgery
5. Neonatology
6. Neurology
7. Obstetrics/Delivery
8. Orthopedic Surgery
9. Other
10. Other Medical
11. Other Surgical
12. Pulmonary
13. Urology/Nephrology

Illness Burden: The Illness Burden for a population is a number used to measure the relative health of that group based upon the number and types of healthcare services used. A higher number indicates that population uses more and/or costlier services and is typical when a greater portion of the group has chronic disease. Likewise, smaller numbers (those below 1.0 - the average), indicate a healthier population using less services. In this report, illness burden will be recalculated only for those with admissions.

Index compares measure values for a specific geographic region or a facility to the state wide average (represented as 1.0). An index above 1.0 means the measure is higher than the state average, and below 1.0 is less than the state average. For example, an index of 1.11 is 11% above the state average, and an index of .83 is 17% below the state average.



Source: <https://www.comedprice.org/#/consumer>

Readmissions, Potentially Preventable (per admission)

PDF Export

	Adams		Alamosa		Arapahoe		State
Completeness Score	C3		C2		C3		C2
Illness Burden Score	1.02		1.20		1.00		1.00
	Re-ad. Rate	Index	Re-ad. Rate	Index	Re-ad. Rate	Index	Re-ad. Rate
▼ Potentially Preventable Readmissions (Claim Rate)							
Potentially Preventable Readmissions (Claim Rate)	4.41%	1.01	2.65%	0.61	3.88%	0.89	4.37%
▼ Potentially Preventable Readmissions (Claim Rate) by Service Line							
Behavioral Health	5.38%	0.85	0.00%	0.00	5.80%	0.92	6.32%
Cardiology	11.19%	1.17	18.18%	1.90	10.21%	1.07	9.59%
Gastroenterology	12.08%	1.18	20.00%	1.95	10.16%	0.99	10.25%
General Surgery	8.32%	1.05	9.52%	1.20	6.13%	0.77	7.94%
Neurology	8.70%	1.12	0.00%	0.00	6.42%	0.82	7.79%
Obstetrics/Delivery	0.47%	0.77	0.68%	1.13	0.48%	0.80	0.61%
Orthopedic Surgery	2.86%	0.74	0.00%	0.00	2.92%	0.76	3.84%
Other Medical	9.11%	1.17	0.00%	0.00	6.28%	0.81	7.78%
Other Surgical	6.54%	1.09	0.00%	0.00	4.85%	0.81	5.98%
Pulmonary	6.90%	1.13	0.00%	0.00	4.65%	0.76	6.13%
Urology/Nephrology	11.37%	0.90	0.00%	0.00	12.64%	1.00	12.69%

Source: <https://www.comedprice.org/#/reports>

OUTCOME VARIABLES

1. Admission counts
2. All Readmission and 30-Day Readmission counts and % of total admissions
3. Various types of Service Lines (created by 3M software)
4. Length of Stay

CLASS VARIABLES

1. Payers – Commercial (for future - Medicaid, Medicare payers)
2. Counties/Cities
3. Facility
4. Age/Sex bands
5. Types of plans – HMO, PPO, POS, Indemnity

Comments/Inputs for Report # 7

1. County/City level of aggregation: suggest we also look into HRR and HAS as alternative aggregation units so that hospitals in those areas can be associated with admissions/readmissions rates.
2. Age Bands: suggest some (e.g., age in years <18, 18-34, 35-44, 45-65)
3. Commercial plan types: Is the suggested plan types informative?
4. Priority: should it be listed as #7 Report?

Hospital referral regions (HRRs) represent regional health care markets for tertiary medical care that generally requires the services of a major referral center. The regions were defined by determining where patients were referred for major cardiovascular surgical procedures and for neurosurgery. Each hospital service area (HSA) was examined to determine where most of its residents went for these services. The result was the aggregation of the 3,436 hospital service areas into 306 HRRs. Each HRR has at least one city where both major cardiovascular surgical procedures and neurosurgery are performed.

Hospital service areas (HSAs) are local health care markets for hospital care. An HSA is a collection of ZIP codes whose residents receive most of their hospitalizations from the hospitals in that area. HSAs were defined by assigning ZIP codes to the hospital area where the greatest proportion of their Medicare residents were hospitalized. Minor adjustments were made to ensure geographic contiguity. This process resulted in 3,436 HSAs. When these regions were created in the early 1990s, most hospital service areas contained only one hospital. In the intervening years, hospital closures have left some HSAs with no hospital; these HSAs have been maintained as distinct areas in order to preserve the continuity of the database.

Report 8: Episode Level Analysis for Select Conditions/Surgeries Total and by Facilities

Objective: This report will create episode level analysis using 3M's proprietary clinical grouper. This will allow us to understand the total cost of a condition, whether acute or chronic. Episode groupers take all expenses in hospital and outside of it and create total cost of treatment, thus allowing us to go past often partial view of total cost of care for a particular condition or surgery. Although the following graphs provide us with total expenditures and frequency in health care costs, we can also get average costs per episode. We can also see episodes of care based on inpatient based events.

The **3M Patient-focused Episodes (PFE)** Software defines two types of episodes from analysis of a patient's inpatient and ambulatory care:

- An event-based episode includes all services within a user-defined time window surrounding a trigger event (e.g., hospitalization, a significant outpatient procedure or outpatient medical visits).
- A cohort episode includes services provided to patients who share a common condition, disease or characteristic within a user-defined period (e.g., pregnancy, diabetes or eligible members of a wellness program).

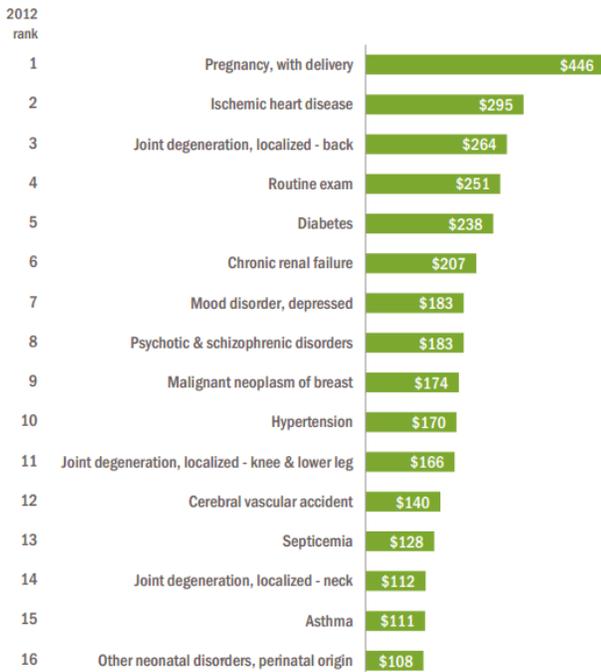
The conventional approach to defining episodes is to focus on the services related to a single disease rather than on the patient as a whole. But for patients with multiple comorbid conditions, individual services cannot be accurately attributed to a specific disease. Comorbid diseases interact and do not behave independently. The 3M model takes a patient-centric approach to defining an episode of care. The 3M PFE Software defines an episode based on all of a patient's healthcare encounters and claims during a specified period, regardless of whether the services are associated with the same diagnosis. A patient may be assigned to zero, one or many episodes (both event-based and cohort) during an analysis period, but only one event-based episode at any point in time.

There are over 500 episodes spanning inpatient and outpatient encounters as well as chronic and acute diseases in 3M's PFE software. It computes actual costs and expected resource utilization for comparative purposes. 3M's clinical model focuses on an enrollee's total burden of illness, not separate disease processes. It also uses a categorical clinical model that classifies patients into mutually exclusive categories, creating a uniform clinical language that can help you identify at-risk patients, costs and inefficiencies.

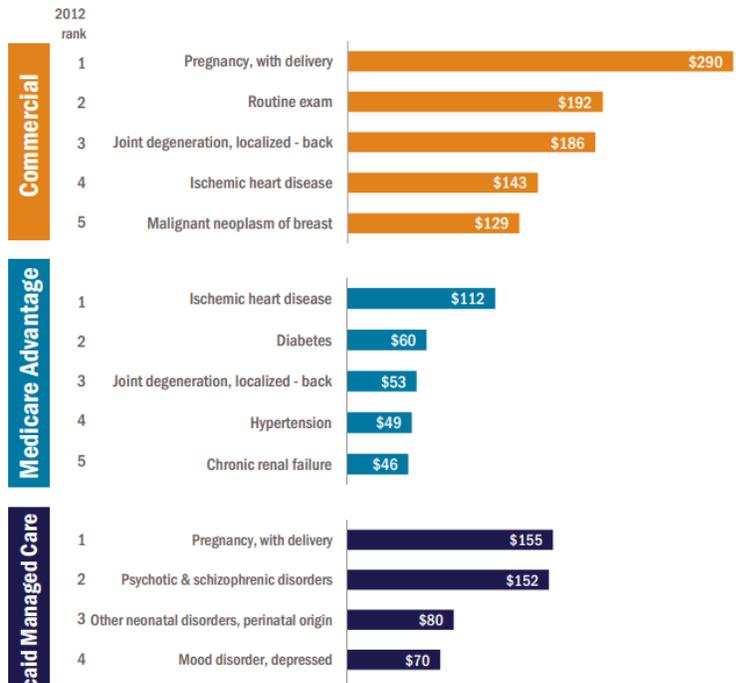
Completeness Score (see earlier definition on page 8)

Illness Burden (see earlier definition on page 7)

Top 20 Episodes by Total Expenditures - Statewide 2012
Dollars in millions



Top 5 Episodes by Total Expenditures - Lines of Business 2012
Dollars in millions



Outcome Variables

1. Costs – allowed, paid, out-of-pocket
2. Counts of services
3. Duration of episodes

CLASS VARIABLES

1. Payers – Commercial (for future - Medicaid, Medicare payers)
2. County/City – TBD at what geographic level
3. Facility
4. Age/Sex bands
5. Types of plans – HMO, PPO, POS, Indemnity

Comments/Inputs for Report # 8

1. County/City level of aggregation: suggest we look into HRR and HAS as alternative aggregation units so that hospitals in those areas can be associated with admissions/readmissions rates.
2. Suggest we compare each facility level episode costs with relative to HRR/HAS and State overall average level
3. Suggest that we compare the Top 20 episodes, or at least number of episodes that reflect 80%+ expenses
4. Age Bands: suggest some (e.g., age in years <18, 18-34, 35-44, 45-65)
5. Commercial plan types: Is the suggested plan types informative?
6. Priority: should it be listed as #8 Report?

Report 9: Density of physicians by specialties (TBD) by cities / counties

Objective: The Primary Care Practitioner (PCP) and other select specialty Density report represent the number of providers per 1,000 persons for a particular specialty in the area. The following are considered PCP providers: Physicians with specialties in Internal Medicine, Geriatric Medicine, Family Practice, General Practice or Pediatrics and Nurse Practitioners with Adult Health, Community Health, Family, Pediatrics or Primary Care specialties. Included can be other specialties – Cardiologists, OB/GYN, Allergist, Anesthesiology, Psychiatry, Emergency Medicine, Orthopedic Surgeons, Ophthalmology, etc. (Source: <https://www.aamc.org/download/313228/data/2012physicianspecialtydatabook.pdf>).

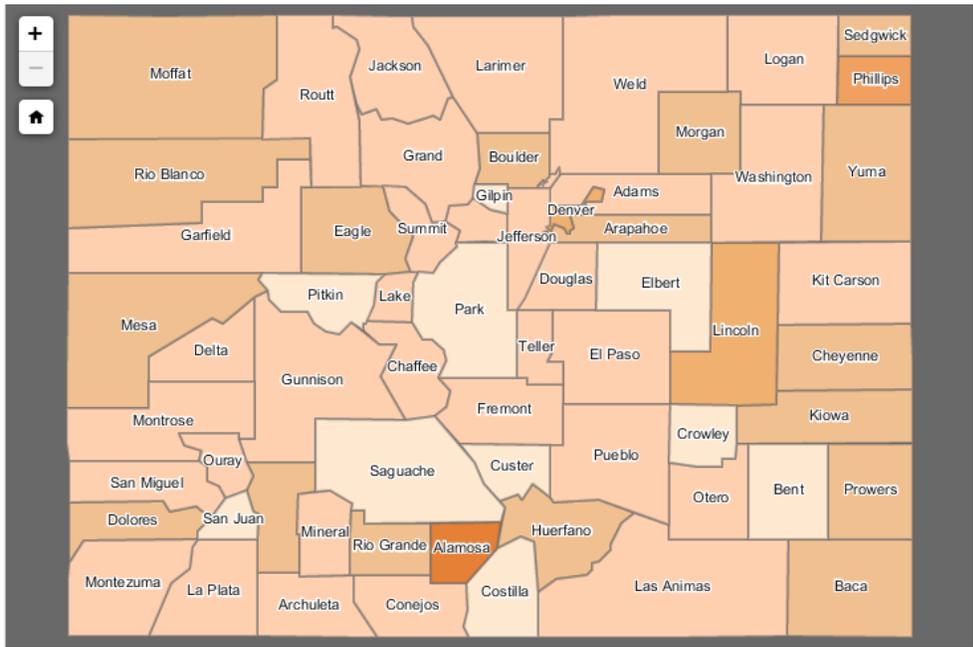
Outcomes definition: Terms used in this report are -

- **Provider Density:** Provider Density represents the number of health care professionals per 1,000 people in the area. Types of providers include Primary Care Practitioners (PCPs), specialists like Cardiologists, and other providers of care including ambulance services, laboratory services, chiropractors and many others.
- **Primary Care Practitioners (PCPs) Density:** Primary Care Practitioner (PCP) Density represents the number of primary care providers per 1,000 persons in the area. The following are considered PCP providers: Physicians with specialties in Internal Medicine, Geriatric Medicine, Family Practice, General Practice or Pediatrics and Nurse Practitioners with Adult Health, Community Health, Family, Pediatrics or Primary Care specialties.
- **Other Providers:** Include Physicians and other healthcare personnel that deliver services that are not deemed primary care, such as specialists and ancillary services.

Index compares measure values for a specific geographic region to the state wide average (represented as 1.0). An index above 1.0 means the measure is higher than the state average, and below 1.0 is less than the state average. For example, an index of 1.11 is 11% above the state average, and an index of .83 is 17% below the state average.

Completeness Score (see earlier definition on page 8)

Illness Burden (see earlier definition on page 7)



No areas selected.

Create Report

- Help**
- [All Current Payers](#)
 - [Compared to Expected \(C2E\)](#)
 - [Completeness Score \(C-score\)](#)
 - [County Index](#)
 - [PCP Density](#)

Legend

PCP Density Per Thousand People

- Less than 2
- 2 to 4
- 4 to 6
- 6 to 8
- 8 to 10
- Greater than 10
- No Data

Source: <https://www.comedprice.org/#/map>

DRAFT

Another View:

	Adams		Alamosa		Arapahoe		State
Completeness Score	C3		C2		C3		C2
Illness Burden Score	0.98		1.07		0.99		1.00
	Value	Index	Value	Index	Value	Index	Value
Provider Density per 1,000 people							
Total Providers	13.5	0.97	29.8	2.14	15.2	1.09	13.9
Primary Care Providers	4.0	1.05	10.6	2.80	4.1	1.08	3.8
Family Practice	1.0	0.82	4.1	3.37	1.0	0.81	1.2
General Practice	*	-	0.1	-	0.1	-	*
Geriatric Medicine	0.1	1.04	0.3	2.41	0.2	2.33	0.1
Internal Medicine	0.8	0.88	2.1	2.48	1.1	1.24	0.9
Pediatric Medicine	0.7	1.53	1.1	2.48	0.5	1.20	0.4
Physician Assistants & Nurse Practitioners	1.4	1.24	2.9	2.57	1.2	1.06	1.1
Other Providers	9.5	0.94	19.2	1.89	11.1	1.09	10.1
Advanced Practice Nursing Providers	0.6	1.08	1.0	1.94	0.5	0.98	0.5
Allergy/Immunology	*	-	0.1	-	*	-	*
Anesthesiology	0.5	0.70	0.0	0.00	0.9	1.24	0.7
Behavioral Health & Social Service Providers	1.1	0.73	3.0	2.11	1.9	1.30	1.4
Cardiology	0.2	0.89	0.7	3.76	0.1	0.76	0.2
Chiropractic	0.2	0.48	0.4	1.01	0.4	1.09	0.4
Dental Providers	0.7	1.24	2.1	3.65	0.6	0.99	0.6
Dermatology	0.1	1.14	0.1	0.56	0.2	1.30	0.1
Diagnostic and Therapeutic Radiology	1.0	1.25	1.2	1.58	1.0	1.32	0.8
Dietary & Nutritional Service Providers	0.0	-	0.0	-	*	-	*
Emergency Medicine	0.6	0.88	1.7	2.78	1.1	1.69	0.6
Endocrinology	0.1	-	0.1	-	*	-	*
Eye and Vision Services Providers	0.2	0.76	1.0	3.03	0.3	1.04	0.3
Family Practice Specialist	*	-	0.0	-	*	-	*
Gastroenterology	0.1	1.01	0.1	0.49	0.1	1.05	0.1
Hematology	*	-	0.0	-	*	-	*
Infectious Disease	0.1	1.79	0.1	1.25	*	-	0.1
Internal Medicine Specialist	0.1	1.16	0.1	1.68	0.1	1.42	0.1
Nephrology	0.2	1.87	0.2	1.94	0.1	0.70	0.1
Neurosurgery	0.1	0.98	0.1	1.23	0.1	1.15	0.1
Nuclear Medicine	*	-	0.0	-	0.0	-	*
Nursing Service Providers	0.1	0.45	0.5	1.86	0.3	0.96	0.3
Obstetrics/Gynecology	0.3	0.97	1.6	4.42	0.4	1.05	0.4
Oncology	0.2	1.25	0.3	2.65	0.1	0.98	0.1
Ophthalmology	0.2	0.99	0.5	2.99	0.1	0.76	0.2
Orthopedic Surgery	0.3	0.91	0.5	1.32	0.3	0.94	0.3
Other	0.1	1.04	0.3	2.41	0.1	0.80	0.1
Other Surgery	0.2	0.73	1.0	4.02	0.2	0.84	0.2
Otolaryngology	0.1	0.91	0.5	4.61	0.1	0.91	0.1
Pathology	0.2	1.36	0.1	0.43	0.1	0.73	0.2
Pediatric Medicine Specialist	0.5	2.55	0.0	0.00	0.2	0.83	0.2

Source: <https://www.comedprice.org/view/reports/pdf.aspx>

Outcome Variables

1. Costs – allowed, paid, out-of-pocket, PMPM
2. Counts of services, Per 1,000 rate
3. Number of Providers per 1,000 members

CLASS VARIABLES

1. Payers – Commercial (for future - Medicaid, Medicare payers)
2. County/City – TBD at what geographic level
3. Age/Sex bands
4. Types of plans – HMO, PPO, POS, Indemnity

DRAFT

Comments/Inputs for Report # 9

1. Report will show costs, services, counts and out-of-pocket costs by physician specialties
2. County/City level of aggregation: suggest county level due to huge swings of utilization and costs in small population, particularly if done on town basis.
3. Age Bands: suggest some (e.g., age in years <18, 18-34, 35-44, 45-65)
4. Commercial plan types: Is the suggested plan types informative?
5. Priority: should it be listed as #9 Report?

Report 10: Costs & Quality Comparisons by Physicians

Objective: The objective of this report is to create price transparency information for consumers for selecting providers. This will allow a consumer to use web-based browsing tools at Connecticut's APCD site to input some information regarding location, plan deductible/coinsurance and types of services like PCP care or Diabetes care and get a list to choose a physician to get the searched services. Since this is going to be based on anonymous browsing, we would not be able to estimate deductible (i.e., out-of-pocket costs) accurately. But if the consumer correctly inputs plan-benefit deductibles/coinsurance, it may be possible to create a good estimate of out-of-pocket costs for the consumer.

Selections:

1. Types of providers List - We can develop a set of provider types from which to select one of interest. This list will go through a lot of analyses before finalizing it. We do not have a preliminary list yet.
2. Distance – this will be a selection item.
3. Insurance Carrier – may not be possible because of existing anti-trust regulations.
4. Plan Type – this is possible and will help in making the rates more accurate.
5. Deductible levels – will have to see how we can get the consumer to input this accurately. Because this will enable him/her to get correct estimates of what the consumer will pay out-of-pocket versus what the insurance carrier will pay.

Quality Transparency:

It is known that consumers prefer to have quality attributes of their physicians in making appropriate choice along with price comparisons. We need to do the following:

3. Based on the characteristic of the consumer, i.e., female or male, age, and chronic characteristics, there should be some claims-based quality markers developed. For example, for a male age 45 with diabetes we should be looking for PCPs who have good track record in managing diabetes care.
4. These care guidelines should conform to the type of providers. In the example below we have three types – Family Medicine, Internal Medicine and Pediatrics. We need to develop claims-based care guidelines to create level of compliance that this provider may have using their patients as the base. If a provider with Internal Medicine manages diabetes, we need to show what % of those patients with diabetes has A1c monitored annually, what % of those patients also have completed lipid profile tests, what % has completed eye exam, etc. This provides state of good patient management as evidenced compliance rates.
5. Provide how many similar people the provider is managing.
6. Provide costs estimates and define it in a way that may be understandable to the consumer.

Wisconsin's Quality & Cost Compare

[CLICK HERE TO SEE THE RATING CRITERIA](#)

LOCATION: 54601 DISTANCE: 10 MILES

		Provides the Recommended Care for Your Healthcare Issue at the Right Time			Makes Good Use of Your Healthcare Dollars			
Family Medicine	Internal Medicine	Pediatrics			Above	Average	Below	
Clinic	City	Above	Average	Below	Above	Average	Below	*Not Rated
CENTER FOR WOMENS HEALTH AT FRANCISCAN SKEMP	LA CROSSE							
FRANCISCAN HEALTHCARE FAMILY HEALTH CLINIC	LA CROSSE							
FRANCISCAN HEALTHCARE FAMILY MEDICINE DEPARTMENT	LA CROSSE							
GUNDERSEN HEALTH SYSTEM	LA CROSSE							
GUNDERSEN ONALASKA CLINIC	ONALASKA							
MAYO CLINIC HEALTH SYSTEM - FRANCISCAN HEALTHCARE IN ONALASKA	ONALASKA							
AVERY R GUNDERSEN CENTER FOR WOMEN	ONALASKA							
MAYO CLINIC HEALTH SYSTEM - FRANCISCAN HEALTHCARE IN LA CROSSE	LA CROSSE							
NEIGHBORHOOD FAMILY CLINICS	ONALASKA							

*NOT RATED COLUMN: INDICATES THAT THIS CLINIC HAS FEWER THAN 3 PHYSICIANS AND/OR DOES NOT HAVE ENOUGH INFORMATION ON PATIENT CARE TO BE RATED BY OUR SYSTEM.

Date Time Period: 04/01/12 to 03/31/13

Source: <http://www.myhealthwi.org/HealthReport.aspx?p=PEDIATRIC&l=54601&d=10%20miles&c=>

Outcome Variables

1. Costs – average professional, average patients' out-of-pocket costs
2. Distance to provider's practice
3. Number of patients
4. Quality markers (TBD)

CLASS VARIABLES

5. Payers – Commercial (for future - Medicaid, Medicare payers)
6. Types of services - TBD
7. Radius of Search – typically in miles
8. Types of plans – HMO, PPO, POS, Indemnity

Comments/Inputs for Report # 10

1. Report will show costs and quality of providers' services (example, PCP care); however without knowing exact plan-benefit design it will be difficult to create accurate patients' share. In addition from claims data there are limited quality markers that can be developed
2. We'll select a set of provider reports that conform to the best practices in the industry. PCP report is an example. We'll perform more research to expand the list.
3. We'll let the user input zip codes to perform the search for a choice of variable radius in miles
4. Commercial plan types: inclusion of this information will narrow the level of accuracy for patients' out-of-pocket costs
5. Priority: should it be listed as #10 Report?