

Inputs from Members

Report	Member Comments	AHA's Timeline	Your Timeline
Disease Prevalence		1	
Population Coverage		2	
ER Utilization		3	
Physician Density		4	
Healthcare Utilization		5	
Population Illness Burden		6	
Total Cost of Care		7	
30-Day Readmissions		8	
Price Transparency - Procedures		9	

Inputs from Members (cont.)

Report	Member Comments	AHA's Priority	Your Priority
Costs of Surgeries by Facilities		10	
Price Transparency – Provider Services		11	
Others?			

Report	Comments from Dr. Mary Alice Lee	AHA's Timeline	Your Timeline
Disease Prevalence	<ul style="list-style-type: none"> <input type="checkbox"/> Estimate based on claims data analysis = "treatment prevalence" and not population prevalence; may not agree with any prevalence estimates reported by DPH based on vital records or statewide surveys. <input type="checkbox"/> Should specify IN ADVANCE the percentage of total CT population represented in the APCD that will be the minimum for reporting prevalence. APCD should include at a minimum the Medicaid claims database before reporting prevalence estimates for the state. Makes no sense to report publicly on the "prevalence of asthma among ConnectiCare customers." Certainly makes no sense for conditions with far greater expected prevalence among lowest income individuals in CT. Makes no sense for reporting by town or geographic area with most covered lives not included in APCD (example C-section rate in Hartford where most births (77%) are to women with Medicaid coverage; DPH has these data from vital records for the entire state). <input type="checkbox"/> Priority: Hold until database can support this kind of measure. Example: Medicaid covers 39% of births in CT. 	1	
Population Coverage	<ul style="list-style-type: none"> <input type="checkbox"/> Do you inventory and description of all CT plans (premiums, deductibles, co-payments, benefits, etc.) and count of number of covered lives by sociodemographic characteristics (age, gender, etc.), and geographic spread, whether or not their data are in the APCD? Do you mean dental insurance too? <input type="checkbox"/> Priority: This seems perfectly reasonable for one of the early reports, helps for marking progress in building APCD, and lays out what needs to be done to complete the APCD. ➤ Example: description of maternity coverage and number of women with coverage would be useful; however, there are about 13,000 births per year with Medicaid, so this isn't a population measure until APCD includes Medicaid data. 	2	
ER Utilization	<ul style="list-style-type: none"> <input type="checkbox"/> Number of visits? <input type="checkbox"/> Number of people ever seen in EDs? Population rate? <input type="checkbox"/> Percent of people who are ever seen in EDs who go 3 or more times in a year (or some such threshold for reporting)? <input type="checkbox"/> Distribution across age groups? Across diagnostic groups? <input type="checkbox"/> Report for visits with ambulatory care-sensitive diagnoses by age? <input type="checkbox"/> Priority: hold. And how is this different (or better) than the ED reporting that DPH/OHA or CHA can report based on CHIME data?? I suspect it will be very different until the APCD is built out. 	3	
Physician Density	<ul style="list-style-type: none"> <input type="checkbox"/> If this is based on just participating insurers, won't come close to what DPH should be monitoring and reporting 	4	
Healthcare Utilization	<ul style="list-style-type: none"> <input type="checkbox"/> Types of services? <input type="checkbox"/> Diagnoses or diagnostic groups? <input type="checkbox"/> Age groups? <input type="checkbox"/> Risk-adjusted how? For state-wide rates (v. local)? <input type="checkbox"/> Count of all services v. count of people with one or more service of the type indicated (EX: number of ED visits v. # and % population with any ED care)? <input type="checkbox"/> Priority: If these counts or rates are reported, MUST make clear what percent of the population is represented by the counts and specifically which insurers' clients are included. Example: Primary c-section rate 	5	
Population Illness Burden	<ul style="list-style-type: none"> <input type="checkbox"/> Not sure what you mean? Which illnesses? <input type="checkbox"/> How is this different from prevalence? <input type="checkbox"/> Priority: Unless I'm misunderstanding the measure, I'd say that this measure should be held until a certain pre-specified portion of the population is included in APCD, including Medicaid. 	6	
Total Cost of Care	<ul style="list-style-type: none"> <input type="checkbox"/> Billed or paid? <input type="checkbox"/> What procedures? Why only elective? <input type="checkbox"/> Inpatient and outpatient? <input type="checkbox"/> Out-of-pocket—very important <input type="checkbox"/> By health plan/insurer until there's a critical mass of claims or population <input type="checkbox"/> Priority: Report but make sure that the limits of APCD data are clearly spelled out and not represented as total costs for CT (payers and citizens). Example: childbirth is one of the most common admitting/discharge diagnoses for hospital care. It is not an elective procedure. 	7	
30-Day Readmissions	<ul style="list-style-type: none"> <input type="checkbox"/> Useful and do-able, but potentially misleading without full participation in APCD..., 	8	
Price Transparency - Procedures	<ul style="list-style-type: none"> <input type="checkbox"/> This is problematic for insurers until the APCD includes nearly all insurers in CT <input type="checkbox"/> Why only elective procedures? <input type="checkbox"/> Priority: may need to hold. Example: cost of c-section (amount billed or paid?) at Hartford Hospital v. YNH v. Sharon v. Waterbury—may be misleading if not all insurers are providing data and if Medicaid isn't included 	9	

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General Comments	<p>Generally:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Very little detail to respond to; requires lots of input from committee members when perhaps the AHA staff or vendor should be drafting the specs for advisory committee to respond to, comment on. <input type="checkbox"/> The types of cuts and cross-tabulations (by town? By provider?) you've suggested will result in really small cell sizes until the APCD is very large. <input type="checkbox"/> Until the APCD reaches a pre-specified level of participation (numbers of insurers + numbers of covered lives as a percentage of the population, including Medicaid), reporting should be internal (and can help with refining specs for the public reporting later). Would be a mistake to rush to produce reports for the public when the results may be very misleading, if not properly represented, and AHA effort in year one should be on building APCD, acquiring data from all major insurers AND Medicaid AND Medicare. 		

Report	Comments from Kimberly Martone	AHA's Priority	Your Priority
Disease Prevalence	Prevalence will have to be among the commercially insured population only. Claims data is incomplete because it does not include Medicare, Medicaid, and age 18-64 uninsured populations which are about 14%, 8%, and 12.5% respectively of the state's population. However, this report (and population burden and healthcare utilization) will be informative to the public and policymakers in terms of what conditions represent the highest burden in the state. The public reports identified as the highest priorities should be consumer-focused.	1	6
Population Coverage	Same as above. Incomplete data.	2	10
ER Utilization	Same as above. Incomplete data.	3	9
Physician Density	We suggest that this report be a priority due to its low effort estimation and short completion as well as the data will complement the departments existing inventory of health care facilities and services. A comprehensive list of services provided by physicians in the state is not available at this point in time. It is essential that this data be captured in this changing health care environment.	4	1
Healthcare Utilization	Same as above. Incomplete data but informative.	5	8
Population Illness Burden	Same as above. Incomplete data but informative.	6	7
Total Cost of Care	Since this report is viewed as moderate effort and medium completion and can be developed for just the commercially insured since the final charge is based on discounted rates, we suggest its completion early on. Total care dollars incurred per person per year by city is an important policy tool.	7	4
30-Day Readmissions	Same as above. Incomplete data.	8	
Price Transparency - Procedures	This report is extremely useful to consumers and will probably be the most widely used report by consumers. Cost by procedure by hospital or surgical center.	9	3

Report	Member Comments 	AHA's Priority	Your Priority
Costs of Surgeries	Even though this report is rated as moderate effort and long completion, total cost of a condition or average cost per episode is valuable information for all audiences.	10	5
Price Transparency – Provider Services	Complimenting the reporting on the distribution of physician services in the state, the cost and quality of these services is extremely valuable to the consumer.	11	2
Others?			

Feedback From: Matthew Katz [<mailto:mkatz@csms.org>]

Sent: Tuesday, March 03, 2015 3:54 PM

Subject: Re: APCD Advisory Group Report Discussion Continued - Special Meeting

Victor- I have taken some time to read the materials and review your comments. Though I agree we don't want to get bogged down and we don't want to micro manage, what is needed are some very specific guiding principles that allow us to best evaluate whether or not these proposed reports or any future reports are consistent with our mission and meet the goal of transparency and actionable information.

I believe, though a good first attempt, what you have outlined below is a bit too broad a charge or more specifically too broad of parameters (guide or guardrails) and doesn't let the committee have a more focused discussion or evaluation of reports or proposed reports. Second, it is at the same time, it is much too limiting as to the kinds of reports that could be proposed or generated.

I am not adverse to parameters so that we don't micromanage, but those outlined parameters must allow for the review and monitoring of report development and also at the same time allow the committee to make recommendations and the staff further justify their determination of report generation.

Unless I missed it, I still haven't seen what reports the vendor first proposed that were selected from to come up with the staff recommended reports and I don't clearly see why these were recommended over or instead of some other reports.

I would like to know what the vendor recommended and why and also why other reports were selected instead of those recommended.

In addition, some of the reports identified will require a great degree of specificity of data and others are more easily reported (the data is reportable). I would like to have a discussion on the cost benefit (analysis) of doing those low hanging reports first - will they demonstrate or provide the utility of the apcd or will they show little or no value to consumers or others and even the little time and effort not be worth it and maybe our time and resources could be better spent on a few high valued but complex reports.

Finally, and I hope we get this tomorrow, I need a clearer understanding on some of these reports as to the intended audience and anticipated time expense (so we understand which reports are time and cost consuming).

Thanks

Matt

Sent from my iPhone
Excuse my typos

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Feedback From: Victor G Villagra [mailto:victorg.villagra@gmail.com]

Sent: Friday, February 27, 2015 2:51 PM

Subject: Re: APCD Advisory Group Report Discussion Continued - Special Meeting

To the APCD Advisory Group

I would like to offer some additional thoughts about the process for choosing APCD reports in a manner consistent with its intended purpose.

In keeping with our discussion at the 2/18/15 meeting, we should make it a goal of our committee to design a public reporting process that will assure that the interests of **consumers** will be front and center at all times. We discussed briefly the idea of creating a structure that would pre-empt any conscious or unconscious bias or narrow interest of committee members to unreasonably limit the practical value of AHA's reports to individual consumers. Beyond the content of the report the number of consumer-centered reports must also be taken into consideration. We could accomplish this consumer-centric goal by adopting a few specific reporting rules.

I sensed there was consensus among committee members about the point raised by Mary Alice Lee that the first 10 reports would be useful to policy makers but not to individual consumers. Faced with considerable pressure to publish the first 10 reports we may all find comfort in delivering "a quick victory" with reports that are technically feasible and relatively easier to assemble. By demanding more of ourselves in future reports I certainly do not want to diminish the professional reward and sense of accomplishment that getting those first 10 will inspire in all of us but especially among the incredibly hard working AHA staff. Acknowledging the considerable challenge of producing consumer-relevant reports I would like to offer these recommendations for the committee's consideration.

Include in our Vision Statement the following

- 1. Half of all public reports will consist of actionable,[\[1\]](#) consumer-centered information. Consumer-centered reports will be published concurrently with any other report.
- 2. No report considered of high-value to consumers and potentially relevant to their health care decisions will be suppressed, obscured or devalued.

I also believe that our committee alone may not be able to fully vet report as being truly useful to consumers. We need to ask "them". This inherent inability of experts (we) to imagine a non-expert's perspective has been amply demonstrated in countless studies.[\[2\]](#) I have no reason to believe we would be an exception. At this point I cannot think of an efficient and effective way to do this without going against my own recommendation not to bog down or micromanage the process.

I am looking forward to the committee's ongoing deliberations

[\[1\]](#) By actionable we mean sufficiently granular and transparent to inform consumers' health care decisions.

[\[2\]](#) You can find a readable summary in Chapter 5 of the popular book Mindwise by Nicholas Epley, Professor of Behavioral Sciences at University of Chicago Booth School of Business. The chapter is entitled "The Trouble of Getting Over Yourself".

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