

Maximizing CMS Data and Information Products for Internal and External Use

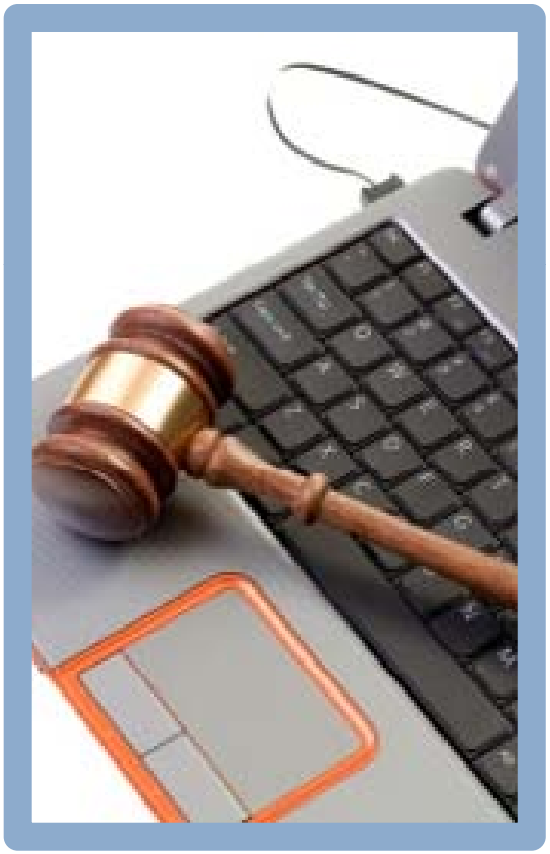
National Committee on Vital and Health Statistics

March 2, 2012

Introduction

- CMS is the largest single payer for health care services in the US
- 1.5 billion claims submitted annually
- Significant additional data sources on the way
  - EHRs
  - Medicare Advantage plan encounter data
  - Health Insurance Exchange/Medicaid expansion data
- Receive billions of other “non-claim” data points
- Transition from a passive payer to active purchaser
- Expected to drive new innovation in health care
- Trusted to protect beneficiary privacy

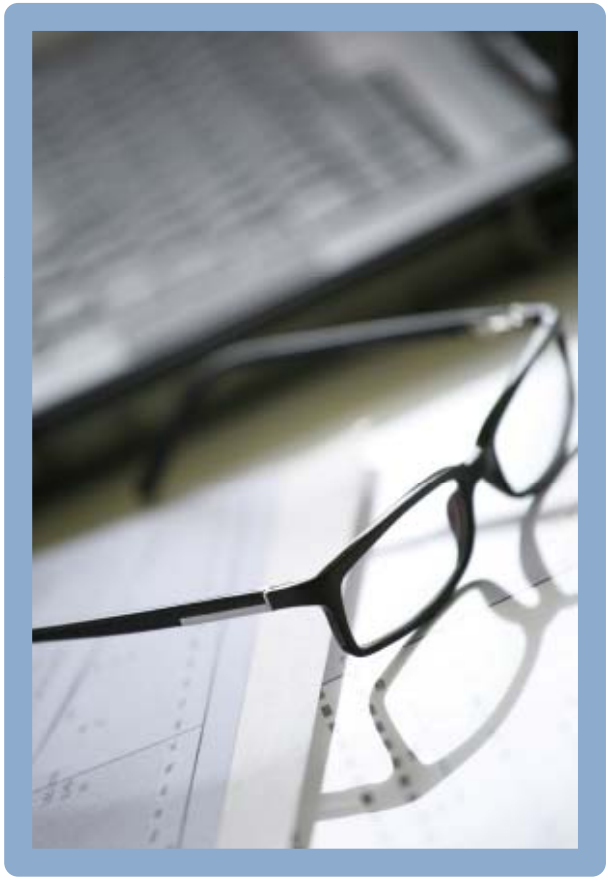
Legal Context For Sharing CMS Data



- **CMS must consider multiple laws in any data release**
  - SSA
  - Privacy Act
  - HIPAA
  - ACA
  - SAMHSA
  - FISMA
- **These laws provide a complex and interactive framework for CMS data use and release policy**

Historical Context for Sharing CMS Data

- Beneficiary identifiable data has been traditionally provided for:
  - "Traditional" research
  - Demonstrations sponsored by CMS
  - Quality Improvement Organizations
- Have NOT traditionally utilized HIPAA provisions to make disclosures to covered entities
- *RESULT: Health care system not benefiting from optimal use of CMS data*



External CMS Data User Needs and Concerns

States

- Need timely data for Medicare/Medicaid care coordination, all payer databases to research health system and general payment reform efforts

Providers

- Need data on the beneficiaries they serve to permit and enhance care coordination and patient centered care
- Need a defined and automated process

Researchers

- CMS data costs too much, is not timely, and comes with too many “strings” attached
- Research data request process not designed to support advent of “big data” analytics and broad-based inquiries

Internal CMS Data User Needs and Concerns

- "Why is it **taking this long** to get a subset of claims data for my program operations?"
- "Why can I only get 2010 data? I need **up-to-date** 2011/2012 data"
- "It needs to be **easier** to get basic information, like enrollment and spending."
- "Why is it this **costly** to get analytic files to my contractors?"
- "We need to disseminate 700,000 physician feedback reports in 2017. **How are we going to get it done?"**
- "We need to **reduce time and increase automation** to collect, analyze and disseminate information."
- "We need an **agile data infrastructure** to meet changing business needs."

Recent Progress in CMS Data Dissemination

- Providing data to ACOs
  - Monthly assigned beneficiary claims data
  - Quarterly summary reports
- Medicare Data Sharing for Performance Measurement
  - 100% extracts of Parts A, B and D data to "qualified entities" with other private/public claims data
- Creation of additional non-beneficiary identifiable data sets
  - Health Indicators Warehouse HRR level data
  - More public use files for comparative effectiveness research

Emerging Uses Will Require New Approaches to Data Release and Dissemination

ACOs and other initiatives are just the leading edge of a new wave of CMS data users

Future data release processes will need to

- Permit routine 100 percent extracts of data across multiple years
- Enable analysis across multiple care settings
- Allow for routine creation of customized analytic files
- Accommodate large increases in number of data users or volume of data

Solution: Transform CMS Approach to Data Analytics and Dissemination

- Employ advanced analytics to create actionable information products
- Establish new policies to support more use and reuse of CMS data
- Expand pool of CMS data users while maintaining appropriate beneficiary protections
  - E.g., establish data enclave/portal to expand secure access to different levels of CMS data for a wider range of users
- Establish dedicated data and information products “line of business” at CMS

How will this Transformation Impact CMS Data Users?

We will strive to ensure that CMS Data becomes….

- ***More Timely:*** timely enough for **real program management and action** (e.g., ACOs, QRUR, and program management).
- ***More Accessible:*** structured to **anticipate questions** ahead of time (e.g., race/ethnicity breakdowns available across programs).
- ***More Intelligent:*** optimized to easily **answer complex questions** (e.g., not just providers with excessive utilization but also who they refer to and the beneficiaries they see).
- ***More Flexible*****:** Individual data extracts can be used for **multiple purposes**.

What will be the Health System Impact of Greater Access to CMS Data?

By making CMS data more timely, accessible, intelligent and flexible for external users we will…..

- Support CMS in becoming a **data driven** value-based purchaser
- Make the **health care marketplace** more transparent to help beneficiaries make the right health care decisions
- Help **providers** move from “maximizing volume of services delivered” to “maximizing health and value delivered”
- Support **community** and **state** efforts to identify variations in care delivery and take action that supports care and health improvement
- Help **researchers** of all kinds advance knowledge about how to improve health and care

Data + Analytics = INFORMATION

- **Greater access to CMS data for users is a key goal but is not enough**
  - **Some users want "raw" data**
  - **But CMS data files and layouts can be intimidating and expensive.**
    - **Can we provide users with the information they need without releasing beneficiary level data?**
  - **How does CMS "unlock" our data to develop insights and information for internal and external users**
    - **Can we create an "information marketplace" based on our data?**
  - **Without data and analytics we cannot establish baselines, identify interventions or evaluate progress relative to our goals**

Partnership for Public Service: From Data to Decision Making

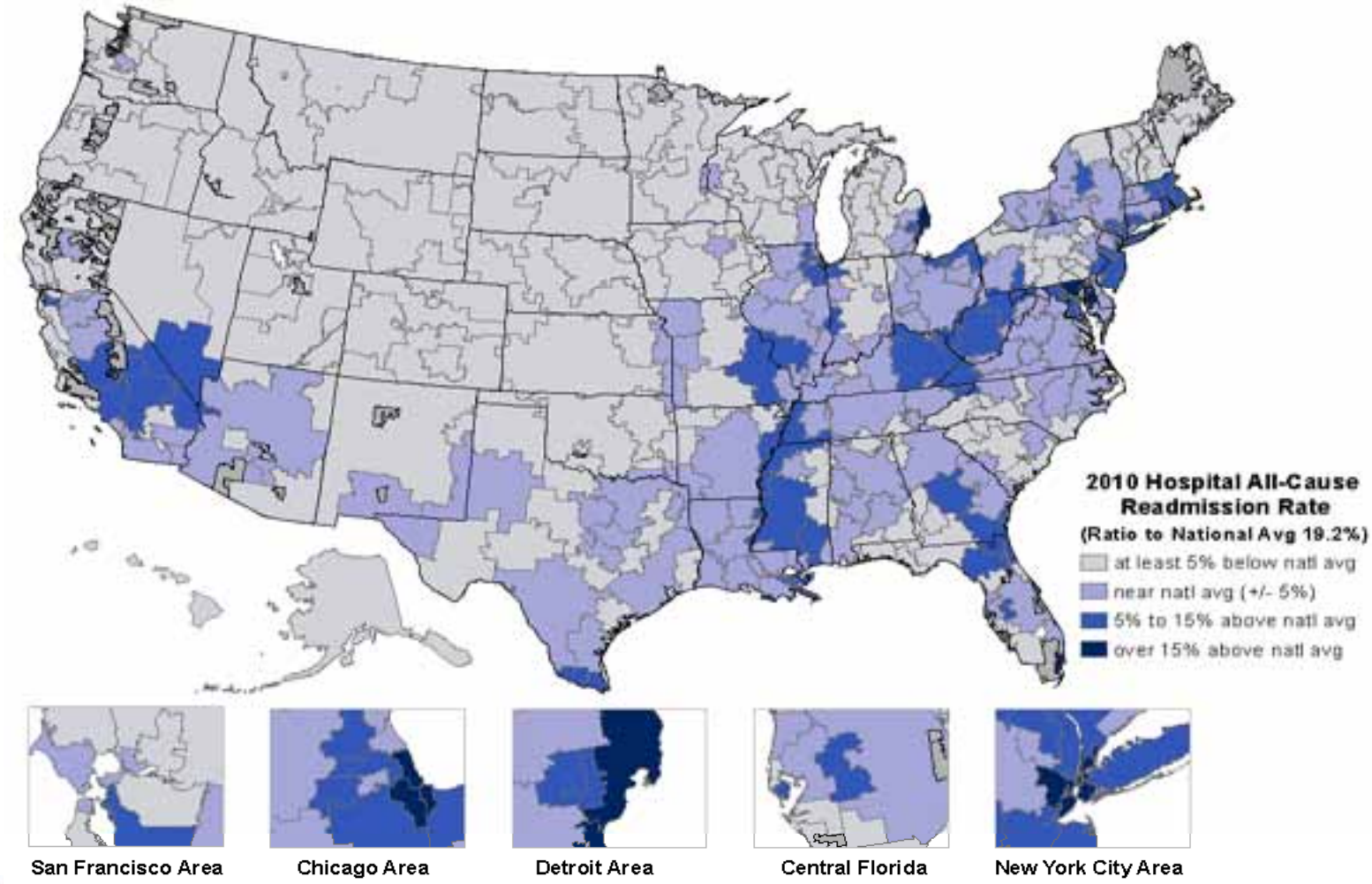
- **"Data is only the starting point….data needs to be analyzed, turned into information and made accessible to staff and executives…..and be understandable to different audiences"**
- **"Myth: Agencies need the latest tools to be successful"**
  - **What matters is <u>leadership commitment</u> to making decisions based on analytics**
  - **Analytic staff more important than analytic tools**

Turning Data into Information: Hospital Readmissions 2007-2010

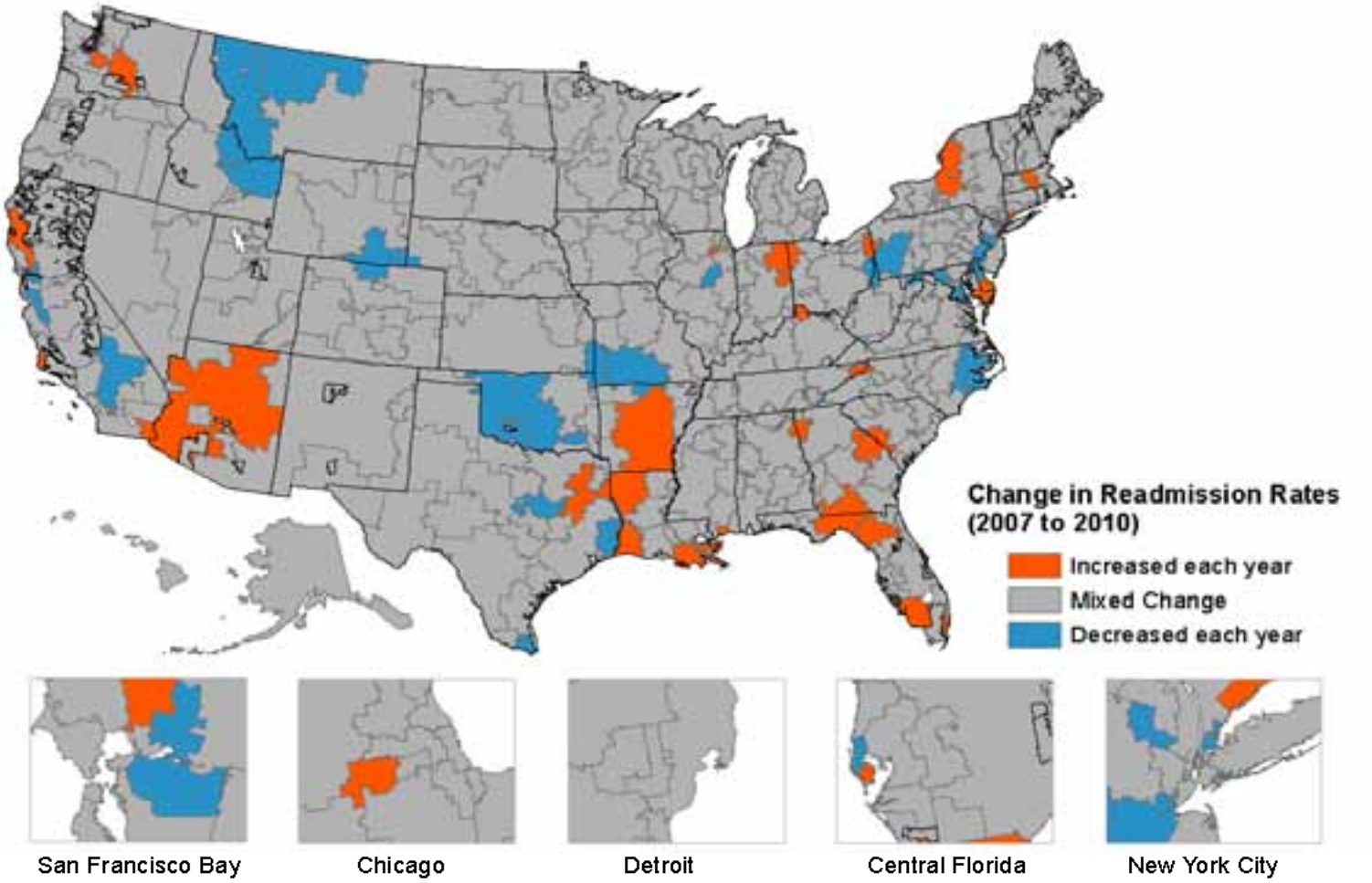
HRR	Readmission Rate 2007	Readmission Rate 2010
AK - Anchorage	16.0%	14.8%
AL - Birmingham	18.4%	18.3%
AL - Dothan	17.1%	16.9%
AL - Huntsville	18.8%	17.8%
AL - Mobile	18.3%	18.6%
AL - Montgomery	18.8%	18.4%
AL - Tuscaloosa	19.5%	18.9%
AR - Fort Smith	16.7%	17.1%
AR - Jonesboro	18.2%	18.2%
AR - Little Rock	18.5%	18.8%
AR - Springdale	17.2%	16.7%
AR - Texarkana	19.7%	19.3%
AZ - Mesa	18.3%	19.6%
AZ - Phoenix	17.8%	18.3%
AZ - Sun City	16.6%	16.9%
AZ - Tucson	16.8%	17.2%
CA - Alameda County	20.9%	21.0%
CA - Bakersfield	19.3%	20.5%
CA - Chico	17.4%	18.8%
CA - Contra Costa County	19.0%	17.8%
CA - Fresno	18.5%	19.4%
CA - Los Angeles	21.7%	22.0%

HRR	Readmission Rate 2007	Readmission Rate 2010
VA - Newport News	17.0%	17.4%
VA - Norfolk	18.2%	18.6%
VA - Richmond	19.0%	19.2%
VA - Roanoke	19.4%	19.1%
VA - Winchester	18.7%	19.1%
VT - Burlington	17.2%	16.8%
WA - Everett	17.0%	16.9%
WA - Olympia	17.1%	15.8%
WA - Seattle	16.8%	16.9%
WA - Spokane	15.0%	15.2%
WA - Tacoma	17.2%	19.0%
WA - Yakima	15.4%	17.1%
WI - Appleton	15.5%	15.4%
WI - Green Bay	16.3%	15.4%
WI - La Crosse	16.1%	16.3%
WI - Madison	16.4%	16.0%
WI - Marshfield	16.9%	17.1%
WI - Milwaukee	18.6%	18.4%
WI - Neenah	15.5%	15.5%
WI - Wausau	18.0%	17.3%
WV - Charleston	21.2%	21.3%
WV - Huntington	20.5%	21.0%
WV - Morgantown	20.3%	20.6%
WY - Casper	15.5%	15.9%

Turning Data Into Information: Hospital All-Cause Readmission Rate (2010)



Turning Data Into Information: Change in All-Cause Readmission Rate (2007-2010)



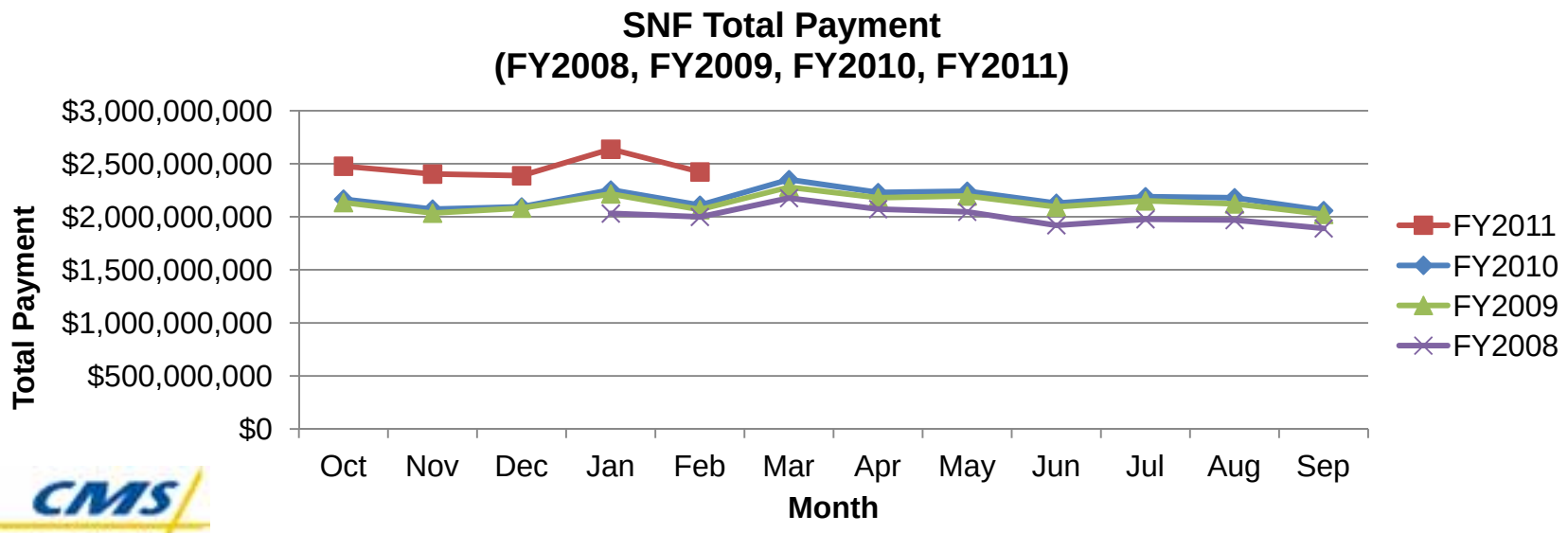
Turning Data into Information: Impact of Medicare Payment Policies on SNF Spending

For profit SNF from Oct. 2010-Aug 2011

White: Skilled Healthcare Pink: Ensign Group
Yellow: Kindred Benchmark S&P: Blue

Turning Data into Information: Impact of Medicare Payment Policies on SNF Spending

- High SNF stock growth + significantly higher Medicare (15%) spending
  - = information that new SNF payment rates not properly calibrated
- CMS able to respond quickly to correct the overpayment by reducing SNF payment by 11.1% in FY 2012 (to surprise of industry and Wall Street)



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Conclusion

- **CMS is committed to becoming a data driven organization to meet both its existing and new responsibilities**
  - **We are transforming how we view and use data, both for internal and external use, while maintaining our longstanding commitment to beneficiary privacy**
  - **We are realigning business practices and policies to better support data information and development**
  - **We are integrating data driven decision making into our everyday work**
- **Questions/Comments?**