

Center for Healthcare Transparency

Led by the Network for Regional Healthcare Improvement & Pacific Business Group on Health

Vision

We will make information on the relative cost and quality of healthcare services consistently and easily available for 50% of the US population by 2020. This information will enable and support:

- public and private purchasers in administering pay-for-value programs
- providers and community organizations in implementing practice transformation and improvement, and
- the general public in making more informed health care decisions.

User needs will determine what we produce. Purchasers seeking to develop global contracts or value based benefit design may require cost and utilization information and patients seeking to choose where to receive care may require outcomes information at the provider, practice and facility levels. Each phase of our work will be driven by the information needs of purchasers and patients and physicians seeking to drive change. Rather than designing our work around currently available information, we will promote the availability of information that is most valued by users.

We will work at multiple levels to address current barriers to transparency. As we understand what information is needed and how it will be used, we will then design an approach to produce it. This will necessarily include the measures and tools that serve as performance indicators as well as the data needed to populate them. It will be necessary to identify reliable measures and access a range of data sources to produce robust cost, quality and patient experience information.

Data access has been a primary barrier to transparency. To enable transparency we anticipate needing to make high quality, reliable, integrated data available to all stakeholders seeking to transform healthcare. To remove existing cost and access barriers, we will seek to understand optimal structures and processes to facilitate data availability for transparency. We will seek to understand the relative merits of regionally aggregated claims and clinical data and more distributed models of measurement and reporting. We will also evaluate other models of data access that could achieve the same level of public transparency and enable creative development of new uses of the data by purchasers, patients and physicians. When cost effective models exist in regions, we will seek to learn from them.

For true population health management and reductions in total cost of care, data contributions from a broad spectrum of care and community based providers, public health and social service agencies, long-term care and others will be necessary to be able to measure the quality and efficiency of care delivery and health outcomes across settings of care and time. This comprehensive data set will initially serve the needs of multi-payer value based purchasing but could also enable secondary uses for research and public health. We expect each region and entity to move toward community wide data sharing and interoperability and integration of all claims, clinical, and patient reported data to enable consistent, standardized data availability across the continuum of care.

Though forms may vary by market, we plan to create a national network of locally governed regional entities that aggregate and make available cost and quality data for both public and private sector users. The regional data entities will make this data available at low cost to appropriate users while protecting patients' privacy and balancing the business and policy objectives of diverse stakeholders. This approach will enable a more flexible and locally responsive infrastructure that includes multi-payer and clinical data aggregation, ensures privacy and security, and drives improvement on a local level, while enabling value based payment of health care services nationwide.

Unless other local solutions exist, each region of the US would be served by a data utility that operates in compliance with federal laws and uses federal standards, while maintaining local autonomy and governance. From 2015-2020, we expect that most regional data entities will build on a foundation of aggregated, multi-payer claims data, gradually adding standardized clinical and patient-generated data.

In most cases, we expect that regional multi-payer commercial claims will be integrated with Medicaid and Medicare data, under the auspices of an expanding Qualified Entity framework. The data would enable flexible and meaningful quality and efficiency measurement for private and public reporting to drive improved quality at lower cost for both commercially insured and Medicaid and Medicare beneficiary populations. The regional entities would also serve the multiple data needs of federal innovation programs such as QIO and the State Innovations Model, enabling consistent, high quality and accessible data for public and private care delivery and payment reform initiatives.

Principles

1. Every region needs access to a reliable, normalized, integrated, usable data set to enable quality and efficiency measurement, reporting and multi-payer value based payment programs.
2. The regional data aggregators will be expected to meet federal functionality, privacy and security standards and laws.
3. Multi-stakeholder governance including public and private purchasers will define functionality standards as necessary beyond federal floor and will include enabling multi-payer value based purchasing, transparency and population health improvement.
4. Regional governance would determine business lines beyond national requirements.
5. Regions could determine their data architecture and approach to claims and clinical data integration as long as federal requirements for functionality, interoperability, privacy and security are met. Regions would be expected to use existing capabilities, adopt innovative approaches to data integration but move to federal interoperability standards within 3 years.
6. Existing federal and state law will enable fair and consistent data access among business associates of covered entities with demonstrated ability to use the data for treatment, payment, health care operations and other allowable uses.
7. All vendors contributing and accessing the data will be expected to meet standards of quality and accountability.
8. Public and private stakeholders will determine how to contribute to the sustainability of a national network of regional data aggregators based on the value derived from their services as allowable under current law.
9. Additional and approved data uses may be developed for the private market to support sustainability and promote innovative approaches to improvement so long as they are permitted by law and protect privacy and security.