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Pennsylvania Health Care Cost Containment Council Performance Evaluation

Conducted Pursuant to Act 2009-3

September 2013

Table of Contents

Page

Summary and Recommendations S-1

I. Introduction 1

II. Management and Visibility 3

III. Quality and Availability of PHC4 Data 13

IV. Need for Reauthorization and Is There a More Cost-effective Way to Accomplish the Council's Objectives 17

V. Issues for Legislative Consideration If PHC4 Is Reauthorized 30

VI. Background 47

VII. Appendices 55

A. PHC4 Response to LB&FC 2007 Report Recommendations 56

B. List of PHC4 Data Users 60

C. Questionnaire to Council Members 70

D. Questionnaire to TAG Members 73

E. Questionnaire to PDAG Members 74

F. Questionnaire to Data Users 75

G. Questionnaire to Interested Parties 77

H. Response to This Report 79

Summary and Recommendations

The Pennsylvania Health Care Cost Containment Council (PHC4) was created in statute in 1986 through the support of a coalition of Pennsylvania businesses, labor unions, and other key stakeholders with the goal of empowering purchasers of health care benefits with information that could be used to improve quality and restrain costs. The PHC4, an independent state agency, collects about four million inpatient and outpatient records each year from Pennsylvania hospitals and ambulatory surgical centers. PHC4 analyzes this data and issues reports about the quality and cost of health care in Pennsylvania. PHC4 received a General Fund appropriation of $2.683 million for FY 2013-14 and currently has a staff of 24.

The PHC4 is scheduled to sunset on June 30, 2014, unless reauthorized by the Pennsylvania General Assembly. Act 2009-3, the act which reauthorized the Council after its 2008 sunset review, directs the Legislative Budget and Finance Committee to conduct a written report of the Council evaluating its management, visibility, awareness, and performance as part of the 2014 review. The report is also to assess whether there is a more effective way of accomplishing the objectives of the Council and the need for reauthorization of the Council.

We found:

Management and Visibility (pp. 3-12)

Achievement of Legislative Mandates (pp. 3-6). Act 2009-3 contains many legislative mandates regarding the composition of the Council and its advisory groups, frequency of Council meetings, data collection requirements, and required reports and outreach programs. Our review found that the Council was in general compliance with those mandates we considered key to the Council's functions, with the exception of a number of mandated reports the Council has not issued. These include annual reports on the rate of increase in the cost of health care in the Commonwealth; annual reports on citizen access to health care; reports on the effect that noninpatient, alternative health care delivery systems have on health care costs; and reports on the utilization of experimental and nonexperimental transplant surgery and other highly technical and experimental procedures. The PHC4's Executive Director noted that the Council does not have the resources to develop and issue reports in all these various areas.

Internal Personnel Policies and Procedures (pp. 6-8). We compared the PHC4 personnel policies and benefits, including travel reimbursement policies, against those of Executive Branch agencies under the Governor's jurisdiction. We found that the PHC4's management policies and procedures are the same as, or

similar to, the policies/benefits offered by the Commonwealth to employees under the Governor's jurisdiction.

Current Contracts (p. 9). The Council reported having 15 current contracts during FY 2012-13. Only one of these contracts was for more than $30,000: a $326,000 contract with Harristown Development Corporation to lease office space (including utilities and janitorial services) for one year. With a current filled complement of 24, this amounts to $13,580 per staff member. In FY 2005-06, PHC4 reported rent/building expense of $269,731 with a filled complement of 51, or $5,290 per staff member. The PHC4's Executive Director noted that the Council reduced its lease space by 1,678 square feet in 2009, but it will not have an opportunity to further renegotiate the lease agreement until the current lease expires in June 2014.

Questionnaire Responses (p. 9). We sent questionnaires to all Council members and to the members of its two statutory advisory groups, the Technical Advisory Group and the Payment Data Advisory Group, soliciting their input regarding a variety of issues, including the management of the Council. Although some made suggestions for improving the Council's operations (including that the Council needs additional funding to achieve its full potential), none of the comments we received expressed concerns regarding the management of the Council or its staff. Several questionnaire respondents commented that the Council is well run, and its staff is courteous and professional.

Implementation of Our 2007 Performance Audit Recommendations (p. 10). Our 2007 performance audit made several recommendations regarding Council policies and operations. Of the seven recommendations we considered most important, the Council has fully implemented four, partially implemented two, and one was rendered moot as a result of changes made in Act 3. Details on the status of all the 2007 LB&FC recommendations can be found in Appendix A.

Visibility to the Public (p. 11). In the 18 months from March 2011 through October 2012, the PHC4 was "in the news" at least 136 times, with exposure in various newspapers and radio and television shows across the state. Additionally, PHC4 noted its reports were downloaded 840,434 times in FY 2011-12. To provide further services to the public, the PHC4 has developed an Internet database of Medicare payments for common health care services to help consumers participating in high deductible health plans or who do not have health insurance coverage to make the most efficient use of their health care dollars.

While, overall, the respondents to our questionnaires gave the PHC4 high marks for its operations, the area in which they received the lowest marks concerned public visibility. For example, five out of the six respondents to a questionnaire we sent to interested parties rated the Council's effectiveness on visibility to

the public as only "somewhat effective." The report contains several of the comments/suggestions we received regarding how the Council could improve its public visibility.

Visibility to the Medical Community (p. 12). Unlike the responses we received regarding public visibility, all the respondents to our interested parties questionnaire rated the PHC4 as either "effective" or "highly effective" regarding the Council's visibility to the medical community. The Council's visibility to the medical community is also demonstrated by the number of requests it receives for data (161 in the past three years).

Quality and Availability of PHC4 Data (pp. 13-15)

Both the Hospital and Healthsystems Association of Pennsylvania (HAP) and the Hospital Council of Western Pennsylvania (HCWP) reported that they found the data collected and reported by PHC4 to be of high quality. HAP noted that hospitals have historically been the biggest users of PHC4 data and view the data as an important resource, especially as regards identifying problems they may have with hospital readmissions. The HCWP reported that the PHC4 data would be more effective if it was more current.

The Pennsylvania Ambulatory Surgery Association (PASA) was much more critical, finding the data and reports PHC4 generates to be "very inaccurate." The PASA concerns appear to stem, at least in part, from differences between how hospitals and ambulatory surgery centers (ASCs) report items such as executive salaries, taxes, and bad debt. Due to these reporting differences (e.g., hospitals deduct executive salaries from income, so it is not included as part of the hospital's profitability, whereas for ASCs that operate as partnerships, the amount distributed to the owners is considered as part of profit), ASCs can appear to be significantly more profitable than hospitals.[1] For example, the PHC4 reported that 2011 operating margins, a key measure of profitability, were 25.02 percent for ambulatory surgical facilities but only 5.58 percent for general acute care hospitals. The ASCs are concerned about the resulting "apples-to-oranges" comparisons with hospitals because insurance companies have used PHC4 profitability reports as a reason to reduce payments to ASCs.

We also found that over the past three years, 161 individuals and organizations have paid amounts ranging from $150 to $83,000 to obtain PHC4 data and special data reports. Of the 29 responses we received from these data users (out of 160 questionnaires sent), all responded that the quality of the PHC4 data was either excellent (23) or good (6). When asked if they found the PHC4 data useful, we had a similar response, with 28 responding that the PHC4 data was either very useful (25) or useful (3).

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[1] PHC4 does explain these issues in their Ambulatory Surgical Facilities report.

Need for Reauthorization and Is There a More Cost-effective Way to Accomplish the Council's Objectives (pp. 17-29)

To address whether there is a need for the PHC4 to be reauthorized, we considered:

PHC4 Published and Special Reports (pp. 17-18). In addition to its annual Hospital Performance and Hospital Financial reports, PHC4 has issued several other more focused reports in recent years that have received wide-spread media coverage and positive comments from the health care community. These include reports on hospital readmissions, potentially preventable hospitalizations, hospital and healthcare-associated infections, and breast cancer surgery.

Other Users of PHC4 Data (pp. 18-20). The Pennsylvania Health Care Quality Alliance, a voluntary coalition of Pennsylvania health care organizations including hospitals, physicians, and health insurers, uses PHC4 data, together with other data sources, to provide health care quality information for consumers and to identify and share best practices. PHC4 data is also being used by the Pennsylvania Hospital Engagement Network (PA-HEN) to demonstrate improvement in hospital care over time. The Informed Patient Institute, a national nonprofit organization to facilitate access to credible online health care information, rated PHC4's cardiac surgery information as a "very good" source of consumer information for care quality and patient safety.

Questionnaire Responses (p. 21). Virtually all the respondents to our questionnaires to Council members, advisory group members, data users, and interested parties thought the PHC4 provided a valuable service and should be reauthorized. Selected comments we received are included in the report text.

Evidence of PHC4's Impact on Health Care Costs and Quality (pp. 20-22). The primary goal of the PHC4 was to empower purchasers of health care benefits, such as business and labor union health/welfare funds, with information that could be used to improve health care quality and restrain costs. While it is possible that PHC4 data has helped to improve quality and restrain costs in some regions, based on the Healthgrades[2] 2013 report on American hospital quality, Pennsylvania, as a whole, appears to perform no better than what would be expected based on national averages. For example, the Healthgrades quality found that, overall, Pennsylvania hospitals rated only "average" in risk-adjusted in-hospital mortality rates during the three-year study period (2009-2011).

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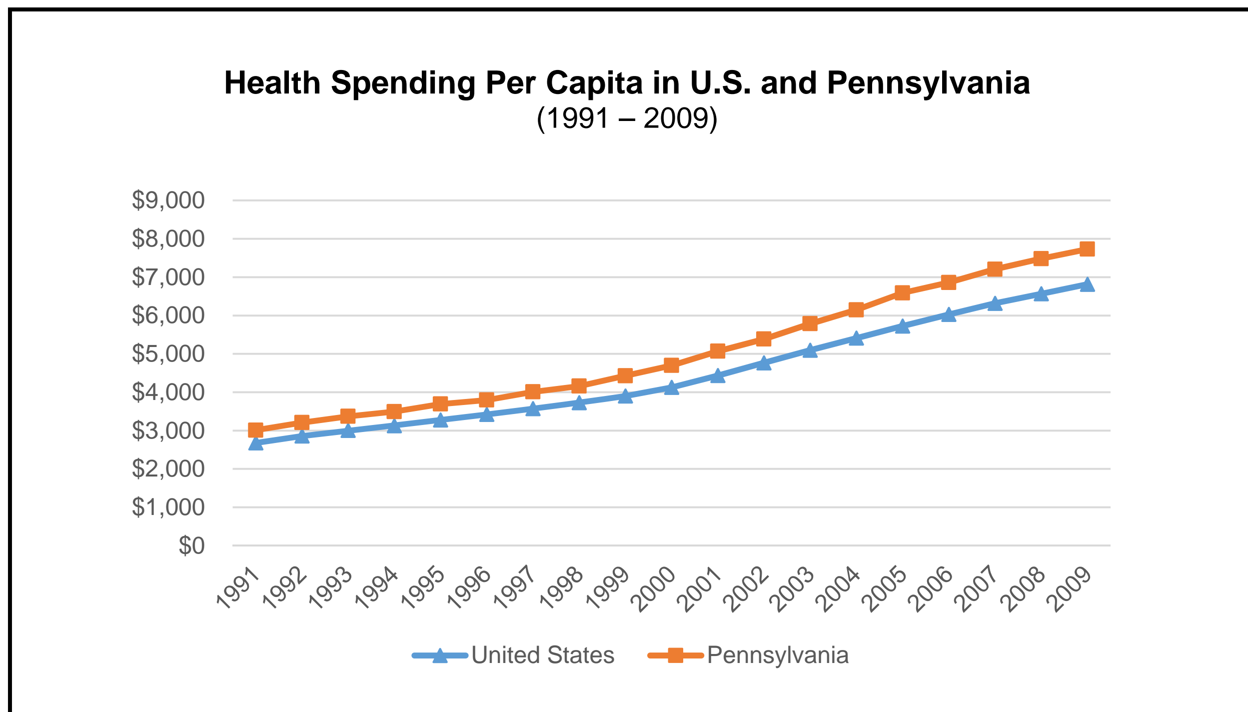
[2] Healthgrades Inc. is a U.S. company that develops and markets quality and safety ratings of health care providers.

With regard to health care costs, as can be seen from the chart below, Pennsylvania health care costs have closely tracked the national average, and have risen at a somewhat faster pace than the national average in recent years.



Academic Research on the Impact of Public Reporting of Health Care Data (pp. 22-23). Our review of the research on the usefulness of public reporting of health care data found mixed evidence regarding the degree to which public reporting may promote changes within health care. While some research shows the public uses such data infrequently when choosing a hospital, other research has found that patients treated in hospitals with intensive public reporting had significantly lower odds of in-hospital mortality than hospitals in environments with limited or no public reporting.

PHC4's Potential Role in Implementing ACA (pp. 23-26). PHC4 envisions playing an important role in the development and monitoring of the federal Patient Protection and Affordable Care Act (ACA) in Pennsylvania, both through its participation in Pennsylvania's State Innovation Model (SIM) grant and through the required and optional reports states will produce under the ACA.

PHC4 noted several specific examples where its objectives align with the federal activities being implemented under the ACA, including:

Hospital Readmissions. Under Section 3025 of the ACA, payments to hospitals may be reduced based on "excess readmissions" for certain conditions Generally, the readmission payment penalty will be up to 1 percent for FY 2013 and up to 2 percent for FY 2014 of a hospital's Medicare base operating DRG (diagnostic related group) payment.

Hospital Value-Based Purchasing Incentive Program. In addition to the readmissions penalty, for FY 2014 hospitals may receive an incentive adjustment of 1.25 percent of a hospital's Medicare operating base DRG, which is withheld from hospital reimbursement and then given back based on the hospital's performance for certain types of conditions.

Hospital-Acquired Conditions (HAC) Penalty. Beginning in FY 2015, the federal Centers for Medicare and Medicaid Services (CMS) will implement a new program mandated by the ACA that will penalize the lowest 25 percent of hospitals in terms of performance on eight hospital-acquired conditions. PHC4 reports that as readmissions and incentive payment algorithms evolve over time, it will be uniquely positioned to inform both the public and technical discussion of these measures and how Pennsylvania providers are affected.

Insurance Exchanges. The PHC4's Executive Director believes the PHC4 would likely have access to exchange-based claims and clinical data that would allow it to compare a number of important metrics involving outcomes and utilization based on coverage type, plan features, and differential patient characteristics that could inform value-based benefit designs for health plans. With such data, the PHC4 believes it could provide research that would allow the citizens and policymakers of the Commonwealth to evaluate the performance and value of the federally-run exchange.

To address whether there is a more cost-effective way to achieve the agency's objectives, we considered:

Fiscal Cutbacks (pp. 26-27). PHC4's appropriation has been cut from $4.019 million in FY 2005-06 to $2.683 million for the past three fiscal years (FY 2011-12 through FY 2013-14). As a result, the PHC4 has cut its staff from 51 in FY 2005-06 to 24 currently. Given these cutbacks, it appears unlikely that, short of a major change in the scope of its mission, significant additional economies could reasonably be achieved.

Merger With the Department of Health (p. 28). The Governor's FY 2012-13 Executive Budget proposed merging the PHC4 into the Department of Health. Several Senators expressed concern during the 2012 budget hearing regarding the possible loss of the Council's independence, the confidentiality of data, and the funding uncertainties that might arise if the PHC4 were to be merged into the Department of Health. The Department acknowledged that "a number of hurdles" existed with this proposal and indicated it has no current plans to revive the merger issue.

Other Data Collection Entities (pp. 28-29). When PHC4 was first established in 1986, it was one of the first in the country to collect and report comparative data on the performance of specific hospitals. Now many organizations collect and report such data, including CMS, the Health Care Cost Institute, the Leapfrog Group for Patient Safety, the Pennsylvania *eHealth* Authority, and others. None of these groups, however, provide the risk-adjusted detail (e.g., laboratory results) or the comprehensiveness of payers (commercial, Medicaid, and Medicare) and patients (all age groups) that are available through the PHC4.

Issues for Legislative Consideration If PHC4 Is Reauthorized (pp. 30-46)

Authorize the PHC4 to Collect and Report Additional Outpatient Data (pp. 30-43). PHC4 collects claims and payment data on health care services and procedures that require either inpatient hospital care or a major ambulatory service. PHC4 is not authorized to collect information on routine outpatient services provided by hospitals, ambulatory service facilities, or in physician offices.[3] Inpatient care, however, comprises only about 22 percent of total health care spending, and outpatient care is growing at a faster rate than any other category of health care spending.

To maintain continued relevancy in this changing environment, many in the medical community believe PHC4 needs to begin collecting expanded outpatient data, including from physician offices. This would provide the actionable data needed to improve patient outcomes and support health care reform, according to the Pennsylvania Medical Society and the Hospital and Healthsystems Association of Pennsylvania. The Act 3 Review Committee report also recommended the Legislature consider expanding the PHC4 authority in several areas, including the ability to provide additional outpatient treatment and payment data.

One approach to collecting such data is through an All Payer Claims Database (APCD). APCDs are large-scale databases that systematically collect health care claims data from a full range of services, including primary care, specialty care, outpatient services, inpatient stays, laboratory testing, and pharmacy, from a variety of payer sources, including Medicare, Medicaid, BC/BS, and commercial insurers. While APCDs can provide information to help assess health care quality and access, the primary purpose of an APCD is to improve price transparency for health care consumers. Fourteen states (Pennsylvania is not among them) currently operate or are in the process of establishing a legislatively mandated APCD.

The PHC4 reports it has successfully tested collecting data in the APCD format with hospitals and ambulatory surgery centers, but that it currently plans to

[3] PHC4 is also authorized to collect data on any initial and follow-up outpatient services associated with the episode of illness before, during, or after the inpatient hospital care or major ambulatory service.

limit its data collection efforts to only those inpatient and outpatient services for which it is authorized to collect data under its enabling legislation.

Developing and maintaining an APCD in Pennsylvania would be a major undertaking for both the insurers that supply the data and for the PHC4. This is particularly the case given the size and complexity of Pennsylvania's health care system. Perhaps tellingly, all of the 14 states that have enacted APCD legislation are relatively small states, the largest being Massachusetts, which has only about half the population of Pennsylvania.

Additionally, each of Pennsylvania's four Blue Cross/Blue Shield plans and the Insurance Federation of Pennsylvania are opposed to Pennsylvania becoming an APCD state for a variety of reasons. Their concerns are enumerated in Chapter V of the report.

Eliminate Certain Mandated Reports and Studies (pp. 43-45). The Health Care Cost Containment Act, Act 1986-89, as amended by Act 2009-3, contains a number of mandates and responsibilities that were included in the Council's original 1986 legislation and that the PHC4 has either never addressed or has not addressed for many years. These include:

Various Annual Reports. Under §5(d)(10), PHC4 is to issue annual reports to the General Assembly on the rate of increase in the cost of health care in the Commonwealth, the effectiveness of the Council in carrying out the legislative intent of the act, the quality and effectiveness of health care, and access to health care for all citizens of the Commonwealth. To some extent, the Council addresses these mandates by issuing annual reports on the performance and financial health of Pennsylvania's hospitals and ambulatory surgery facilities and an annual report on Council activities. These reports do not, however, address the rate of increase in the cost of health care or the quality and effectiveness of health care in areas other than hospitals and ambulatory surgery facilities, nor do they address the issue of access to health care.

Noninpatient, Alternative Delivery Systems. Under §5(d)(12), the PHC4 is to conduct studies and publish reports analyzing the effects that noninpatient, alternative health care delivery systems have on health care costs. The PHC4 reports on the financial status of ambulatory surgery facilities, but these reports do not indicate the effect they have on health care costs. PHC4 also compiled annual reports on the quality of commercial HMOs, but has not released a new HMO report since April 2008.

Experimental and Nonexperimental Transplants. Under §5(d)(13), the PHC4 is to conduct studies and make reports concerning "the utilization of experimental and nonexperimental transplant surgery and other highly technical and experimental

procedures, including costs and mortality rates." The PHC4 reports it has not conducted any studies under this provision since 1994.

Indigent Care Studies. Under §8(c), at the request of the Governor or General Assembly, the PHC4 is to conduct studies on the costs and most appropriate means of providing indigent care. The PHC4 conducted an indigent care report in 1988, but has not been requested and has not conducted a subsequent report. This appears due, at least in part, to Congress having enacted legislation in 1986 requiring hospitals to provide care to anyone needing emergency health care treatment regardless of their ability to pay, which largely eliminated the initial concerns embodied in this provision of the act.

Mandated Health Benefit Studies. Under §9, upon the request of appropriate committee chairs of the House and Senate or upon the request of the Secretary of Health, the PHC4 is to provide information on proposed mandated health benefits. The PHC4 has prepared 22 such reports, but none since 2008. These types of reviews are costly to conduct and appear to have had little or no influence on the adoption or rejection of specific mandated benefits. PHC4 estimates that if a preliminary review indicates it should proceed with a formal benefit review panel, it could incur costs in excess of $100,000.

Other Issues (pp. 45-46). Other issues raised pertaining to the PHC4's enabling legislation involve the Council's sunset termination dates, expanding the Council's membership to include a representative from small businesses, and PHC4 reporting on the performance of public and private insurers.

Recommendations

We recommend:

1. ***The House and Senate Standing Committees conducting the PHC4 sunset review consider authorizing the PHC4 to collect additional outpatient data*.** Authorizing the PHC4 to collect additional outpatient and other data would allow the PHC4 to obtain the data necessary to support objectives established by the Commonwealth should it receive federal funding to implement its Statewide Healthcare Innovation Model plan. Even if such funding is not forthcoming, authorizing, but not necessarily requiring, the PHC4 to collect additional outpatient data would address concerns expressed by the Hospital and Healthsystem Association of Pennsylvania, the Pennsylvania Medical Society, and others that additional outpatient data is critical to improving patient outcomes and supporting Commonwealth efforts toward health care reform.

2. ***The House and Senate Standing Committees conducting the PHC4 sunset review consider eliminating mandated reports and studies contained in the PHC4's enabling legislation that are no longer deemed important.*** Given the PHC4's fiscal cutbacks, expecting it to complete all the statutorily mandated reports appears unrealistic.

3. ***The PHC4 undertake steps to improve its visibility to the public.*** To some extent, PHC4's outreach efforts are limited by its budget, but this was the one area in which a significant number of our questionnaire respondents believed the PHC4 has not been particularly effective.

4. ***The PHC4 review the concerns expressed by the Pennsylvania Ambulatory Surgery Association regarding how it presents profitability (operating margin) information.*** At least some of the difference in the operating margins the PHC4 reports between hospitals and ambulatory surgical centers appears due to how the two types of facilities report their financial information rather than true economic substance. Although the PHC4 does disclose these differences in their reports, discussing the matter with PASA may result in additional steps to address this issue.

5. ***The PHC4 negotiate a lower cost lease in June 2014.*** The PHC4's lease agreement with Harristown Development Corporation for office space, utilities, and janitorial service expires in June 2014. With a reduced staff, there should be an opportunity to reduce its $326,000 annual lease expense.

6. ***The PHC4 renew its efforts to fill the two vacant gubernatorial appointments to the Council.*** The Council positions for a representative of nurses and a representative of health maintenance organizations have both been vacant for several years.

I. Introduction

Act 2009-3, which reauthorized the Pennsylvania Health Care Cost Containment Council (PHC4), also directed the Legislative Budget and Finance Committee (LB&FC) to evaluate the performance of the Council. Under Act 3, the Council is scheduled to sunset on June 30, 2014, unless reauthorized by the General Assembly.

Study Scope and Objectives

This study evaluated the performance of the Council focusing on the period FY 2009-10 through FY 2012-13. Specifically, the study sought to assess:

- the adequacy of Council management;
- the visibility of the Council to consumers, providers, purchasers, researchers, and public officials;
- the quality of data used in the Council's public and special reports;
- whether there is a demonstrated need for the Council and whether there is a more cost-effective way to achieve the Council's objectives; and
- whether there is a continued need for the Council and, if so, what legislative changes the General Assembly may wish to consider as part of a reauthorization bill.

Methodology

To evaluate the management of the Council, we reviewed the Council's statutory mandates; internal personnel and operating policies and procedures; Council, Technical Advisory Group, and Payment Data Advisory Group meeting minutes for the past three years; and the Council's FY 2012-13 contracts.

We also sent questionnaires to each member of the Council, its advisory groups, data users, and other interested parties, including the Hospital and Health Systems Association of Pennsylvania, the Pennsylvania Medical Society, the Hospital Council of Western Pennsylvania, Independence Blue Cross, Highmark Blue Shield, Blue Cross of Northeastern PA, the Lehigh Valley Business Coalition on Health Care, the Insurance Federation of Pennsylvania, and the Pennsylvania Ambulatory Surgery Association, among others. Copies of the questionnaires and tallies of the respondent answers are included in Appendices C, D, E, F, and G.

We reviewed findings from the Council's three most recent financial audits and reviewed the extent to which the Council had implemented the recommendations contained in our 2007 sunset performance audit. We also reviewed the findings and recommendations of the Act 3 Review Committee report issued in June 2010.

To assess the quality of data used in the Council's public and special reports, we contacted that Hospital and Healthsystems Association of Pennsylvania, the Hospital Council of Western Pennsylvania, and the PA Ambulatory Surgery Association as representatives of the major data providers. We also sent questionnaires to 160 individuals and organizations that obtained PHC4 data in the past three years soliciting their opinion on the quality and usefulness of the PHC4 data.

To assess the visibility of the Council to consumers, providers, purchasers, researchers, and public officials, we reviewed television, radio, and press articles citing Council reports and activities. We also included a question regarding the visibility of the Council to the public and to the medical community on the questionnaires we sent to Council members, data users, and other interested parties.

To assess the continued need for the Council and whether its objectives could be achieved in a more economical manner, we considered information from all of the sources cited above regarding the usefulness of the Council's data and reports in achieving the Council's objectives. A question soliciting an opinion on the continued need for the Council was also included in all our questionnaires. An assessment of the data collected and reported by other state and national organizations and the potential impact of the federal Patient Protection and Affordable Care Act—particularly the data collection and reporting provisions of that act—are also included.

Acknowledgements

We express our appreciation to the Pennsylvania Health Care Cost Containment Council members and staff. We also thank the members of the Council's advisory groups and the various business, labor, health care providers and provider associations, insurers, and others who assisted our work.

Important Note

This report was developed by Legislative Budget and Finance Committee staff. The release of this report should not be construed as an indication that the Committee or its individual members necessarily concur with the report's findings and recommendations.

Any questions or comments regarding the contents of this report should be directed to Philip R. Durgin, Executive Director, Legislative Budget and Finance Committee, P.O. Box 8737, Harrisburg, Pennsylvania 17105-8737.

II. Management and Visibility

Our assessment of PHC4's management is based largely upon whether the Council has accomplished and adhered to key mandates of its enabling legislation, the Health Care Cost Containment Act, Act 1986-89, as re-enacted and amended by Act 2009-3, and whether the Council's internal policies and procedures appear reasonable when compared to other Executive Branch agencies. We also reviewed Council meeting minutes for the past three years to identify any concerns expressed by Council members, solicited comments regarding the management of the Council from current Council members and other interested parties, and reviewed the Council's response to the recommendations from our prior (2007) report. We assessed the visibility of the Council to both the public (primarily through media reports) and to the more narrowly focused medical community (primarily through data requests).

Management

Review of Mandates From the PHC4's Enabling Legislation

Council Membership. The statute creates a 25-member Council. The Council currently (August 2013) has two vacancies, one representing nurses and one representing managed care organizations. Each of these positions has been vacant for several years. The PHC4 Executive Director indicated he has notified the Pennsylvania Nurses Association (the nominating organization for the nurse position) several times about the vacancy. Regarding the managed care position, there is apparently a lack of clarity on how this nomination should occur that has to do with the fact that the nominating organization originally named in the statute, the Pennsylvania Managed Care Association, no longer exists.[1]

Council Meetings. The statute stipulates that the Council is to meet at least once every two months and is to publish a schedule of its meetings in the *Pennsylvania Bulletin* and at least one newspaper of general circulation at least once in each calendar quarter. Between May 2010 and March 2013, the Council met on 18 different occasions. With one exception, the Council met the "at least once every two months" requirement. The exception, a four-month period between the September 2012 meeting and the January 2013 meeting, occurred because the November 2012 meeting was cancelled due to Hurricane Sandy. The PHC4 publishes notice of its meetings in the *Pennsylvania Bulletin* at least 24 hours in advance of the meeting, and Council and Committee meetings are advertised in the Harrisburg *Patriot News* typically the week prior to the meeting.

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[1] Reference to the Pennsylvania Managed Care Association was removed when the PHC4 was reauthorized in 2009.

Advisory Groups. The Council's enabling legislation establishes two advisory groups, the Technical Advisory Group to respond to issues presented to it by the Council and the Payment Data Advisory Group to assure the technical appropriateness and accuracy of payment data. Both these groups are established and meet periodically (the TAG met three times in 2010, three times in 2011, and once in 2012; the PDAG met six times in 2010, once in 2011, and twice in 2012).

Data Collection. Act 3 provided that the PHC4 "shall not require any data sources to contract with any specific vendor for submission of any specific data elements to the council." This provision addressed the concern of hospitals and others that the Council's reliance on a specific third-party vendor (MediQual), which required hospitals to purchase a software license and incur additional medical abstraction work for many hospitals, was unduly burdensome to hospitals. The act also requires that "The Council shall maintain a list of at least two vendors that may be chosen by any data source for submission of any specific data elements." The Council no longer contracts with MediQual and now does the risk-assessment function in-house. As of the end of 2010, the PHC4 had identified two vendors that met the required specifications. PHC4 noted that this list is not closed and will be an ongoing process.

Reports. Under its enabling legislation, the Council is to make the following reports:

- *An annual report to the General Assembly on the rate of increase in the cost of health care in the Commonwealth and the effectiveness of the Council in carrying out the legislative intent of the act:* It is also to make annual reports on the quality and effectiveness of health care and access to health care for all citizens of the Commonwealth. The Council addresses these mandates by issuing annual reports on the financial health of Pennsylvania's general acute care hospitals and ambulatory surgery facilities. The Council also issues annual reports on the performance of hospitals and ambulatory surgery facilities using risk-adjusted data and an annual report on Council activities. These reports do not, however, address the rate of increase in the cost of health care, nor do they address the issue of access to health care.
- *Reports on the effect that noninpatient, alternative health care delivery systems have on health care costs, including but not limited to HMOs, PPOs, primary health care facilities, home health care, attendant care, ambulatory service facilities, freestanding emergency centers, birthing centers, and hospice care:* The PHC4 issued reports on the financial health of ambulatory surgical facilities in 2010 and 2011. While the reports did not explicitly address the impact of these facilities on health care costs, they did contain information that could be helpful in such an analysis. PHC4 also issued

annual reports on the quality of commercial HMOs, but has not released a new HMO report since April 2008 (covering 2006).

- *Utilization of experimental and nonexperimental transplant surgery and other highly technical and experimental procedures:* The PHC4 reported it issued one report regarding transplants in 1994.
- *Provider quality and service effectiveness:* The Council is to issue reports on provider quality and service effectiveness on diseases or other procedures that "represent the best opportunity to improve overall provider quality, improve patient safety and provide opportunities for cost reduction." The PHC4 has released reports on hospital performance; breast cancer; cardiac surgery; diabetes; knee, hip, and shoulder replacement surgery; hospital acquired infections; and potentially avoidable hospital readmissions that address issues of provider quality, service effectiveness, and opportunities for cost reductions. These reports include performance measures such as risk-adjusted mortality rates, readmission rates and reasons for readmissions, incidences in Pennsylvania compared to national averages, hospitalization rates by age groups and race, average lengths of stay, hospital charges, and Medicare payments.[2]
- *Special reports to any purchaser:* The PHC4 has developed 161 special reports for users over the past three years (see Chapter II).
- *At the request of the Governor or General Assembly, conduct studies on the costs and most appropriate means of providing indigent care:* The PHC4 reports it has not been requested, and therefore has not conducted, any such reports since 1988.
- *Upon the request of appropriate committee chairs of the House and Senate or upon the request of the Secretary of Health, provide information on proposed mandated health benefits:* The PHC4 has done 22 preliminary reports (none since 2008), but has convened only one Mandated Benefit Panel (concerning autism spectrum disorder) to further study any of these issues. Although difficult to know with certainty, the impact of the autism Panel's report does not appear to have affected the outcome of the legislation as the legislation was near passage when the report was released.

Outreach Programs. The Council is to develop and implement outreach programs "designed to make its information understandable and useable to purchasers, providers, other Commonwealth agencies, and to the general public." In our questionnaire to Council members, we asked them to rate the Council's effectiveness in implementing such outreach programs. Of the thirteen Council members responding to the question, four rated the Council's outreach efforts as "highly effective," five as "effective," and four as "somewhat effective."

[2] Not all reports contain all measures.

In March 2011 PHC4 created an interactive database of Medicare payments for common outpatient treatments as part of its outreach efforts. The database provides consumers with information regarding the amount Medicare pays hospital outpatient departments and free-standing outpatient centers for 78 common services, treatments, and procedures including colonoscopies, cataract surgeries, and MRIs. The online service is searchable for all 67 Pennsylvania counties.

Review of Internal Policies and Procedures

We reviewed the Council's internal management policies and procedures to assess them against those used in Executive Branch agencies under the Governor's jurisdiction. We found that, in most respects, the PHC4's management policies and procedures are the same as, or very similar to, the policies/benefits offered to Commonwealth employees under the Governor's jurisdiction. A comparison of the benefits packages is shown below.

Number of Paid Holidays. There are 11 holidays for both employees under the Governor's jurisdiction and employees of the PHC4.

Vacation Days. Employees under the Governor's jurisdiction hired prior to July 1, 2011, are eligible for annual leave after 30 calendar days of service with the following schedule: 0 to 3 years, 7 days of annual leave; 3 to 15 years of employment, 15 days of leave annually; 15 to 25 years of employment, 20 days of leave annually; over 25 years of employment, 26 days of leave annually. Employees hired after July 1, 2011, shall be eligible for annual leave at the same schedule except they are only eligible for a maximum 20 days of vacation. The only difference for PHC4 employees is that employees with 0-3 years receive 10 days of annual leave.

Unused annual leave can be carried over to a maximum of 45 days and are compensated 100 percent for the unused days for employees under both the Governor's jurisdiction and PHC4 employees.

Sick Days. Sick days awarded and paid at separation are identical for PHC4 employees and Commonwealth employees under the Governor's jurisdiction. They are as follows: 13 sick days (11 days after January 1, 2012) awarded annually. Employees must work 30 calendar days to use paid sick leave. Employees may accumulate sick leave up to a maximum of 300 days paid upon separation at the following schedule: employees with 0 to 100 sick leave days will be paid for 30 percent of their accumulated sick leave, employees with 101 to 200 of accumulated sick leave will be paid for 40 percent of their accumulated sick leave; employees with 201 to 300 accumulated sick days will be paid for 50 percent of their accumulated sick leave. In addition, employees with more than 300 accumulated sick days are paid 100 percent for unused sick leave earned in the last year of employment. To be

eligible for sick leave payout employees must have a minimum of five years of service under the state retirement system.

Health Insurance. Employees under both the Governor's jurisdiction and PHC4 are provided health benefits through the Pennsylvania Employees Benefit Trust Fund (PEBTF). Options are a PPO and an HMO. PHC4 employees also have the option to participate in a Consumer Driven Health Plan, but most PHC4 employees have chosen the PPO. Coverage includes dental, vision, and prescription coverage. Employee contributions towards health coverage have two components:

- 3 percent of employees base salary, which is reduced to 1.5 percent if the employee participates in the disease prevention/wellness program.
- Employees hired after August 1, 2003, pay an additional cost to enroll in the PPO due to the additional cost of the plan. For 2013, the "buy-up" cost for single coverage is $46.32 per month and the "buy-up" cost for family coverage is $117.34 per month. After six months, dependent coverage for the least expensive health plan is provided free. If a more costly plan is purchased, employees must pay the difference.

The health benefits have no annual deductible, a $15 primary care copayment, $25 specialist copayment, and a $50 emergency room copayment (in-network) that is waived if admitted. Prescription copay is $10 for generic and $18-$36 for brand name. These features are the same for both employees under the Governor's jurisdiction and PHC4.

Life Insurance. Employees under the Governor's jurisdiction and PHC4 are provided with group life insurance, which is 100 percent employer-paid and equal to an employee's annual salary, up to a maximum of $40,000 for most groups. Employees can purchase additional life insurance coverage at their expense.

Pension/Retirement. Employees under the Governor's jurisdiction and PHC4 participate in the SERS defined benefit plan. Most employees contribute 6.25 percent of their salary toward retirement. When employees retire the amount of the monthly retirement benefit they receive is determined by a formula that takes into account the employee's retirement age, number of years of credited service, and final average salary. Additionally, employees may participate in a deferred compensation program, which is not matched by the state.

Disability. The Commonwealth provides Long Term and Short Term Disability coverage to employees. PHC4 allows employees to purchase Long Term Care insurance at their own cost if they desire that benefit.

Educational Expenses. On a limited basis, the Commonwealth will reimburse for specific courses for academic credit if they are needed for an employee's job

duties, but not for pursuit of an academic degree per se. PHC4 employees may receive up to $1,000 reimbursement annually for pre-approved education classes.

Travel Reimbursement. Although the employee manual for PHC4 does not contain specific rules regarding reimbursement of travel expenses, the appendix "Travel Expense Voucher" is identical to that utilized by employees under the Governor's jurisdiction, including mileage rates allowed. The PHC4 Executive Director informed us they do follow the Commonwealth's recommended policies where applicable, such as mileage (travel), lodging, and subsistence rates based on guidelines set forth by the Governor's Office and the U.S. General Services Administration.

Overtime/Compensatory Time. Both the Commonwealth and PHC4 allow employees to be granted compensatory time in lieu of overtime pay, one hour for each hour of pay earned. For Commonwealth employees, the maximum accrual of compensatory time hours in lieu of overtime is 240 hours. The PHC4 policy on compensatory time is similar, but more specific with regard to the circumstances under which leave will be earned and used, citing special projects and unusual circumstances.

Supplementary/Dual Employment. Both PHC4 and the Commonwealth anticipate that employees may want to participate in employment outside of their respective organizations, however, applicable procedures and rules are more stringent for employees under the Governor's jurisdiction. Commonwealth employees must file supplementary employment requests with their agency head or designated official who will either approve or disapprove the requests. This includes self-employment. Approval for supplementary employment must be obtained prior to accepting such employment for current employees and prior to employment with the Commonwealth for prospective employees.

Employees of PHC4 have no requirement to get supplemental employment approved prior to its commencement. Employees of PHC4 also have appeal rights should the Executive Director, once notified, deem that there is a potential for conflict, whereas under management Directive 515.18, any conflicts arising out of supplementary employment are to be resolved in favor of the Commonwealth.

Policy statements regarding dual employment at both entities are identical, citing that there is to be no conflict in hours worked allowed and the additional Commonwealth job cannot be such that it could influence the employee in the discharge of official duties.

Review of Current Contracts

The Council reported having 15 current contracts during FY 2012-13 and one Memorandum of Understanding with the Governor's Office of Administration for ongoing support services for payroll/HR. Of the 15 contracts, only one was for more than $30,000: a $326,000 contract with Harristown Development Corporation to lease office space (including utilities and janitorial services) for one year. With a current filled complement of 24, this amounts to $13,580 per staff member.

In FY 2005-06, PHC4 reported rent/building expense of $292,592 with a filled complement of 51, or $5,737 per staff member. The PHC4's Executive Director noted that the Council reduced its lease space by 1,678 square feet in 2009, but that it will not have an opportunity to further renegotiate the lease agreement until the current lease expires in June 2014.

Review of Council Meeting Minutes

We reviewed the meeting minutes of the 18 Council meetings held between May 2010 and March 2013. The minutes include relatively little discussion during this period specifically pertaining to the management of the Council or staff. The Council's Executive Director noted in January 2013 that the discussions in 2012 surrounding the possible consolidation with the Department of Health had a significantly negative impact, with a near 70 percent loss of staff in the information services department, including the Director. He noted the Director of IS has since returned, but staffing is still down 50 percent in that area.

The Executive Director also commented on the importance of the information technology upgrades to streamlining and modernizing some of the activities that had previously been done manually. He noted that one of the reasons the agency has been able to get through all its fiscal and staffing cuts has been the advantage of information technology resources and that new upgrades approved will further increase efficiency and productivity.

Questionnaire Responses

In the questionnaires we sent to Council members, we asked if they had any suggestions for improving the Council's management procedures and policies. Two Council members made the following two suggestions.

- More incentives for members of PHC4 and interested parties to attend meetings and promote more public use of information.
- Focus on end user needs with less concern for labor and industry policies.

We also asked the TAG and PDAG members if they had comments regarding the Council's operations or functions. None of the comments we received expressed any concerns regarding the management of the Council staff. Several questionnaire respondents commented that the Council was well run and its staff was courteous and professional.

Implementation of 2007 LB&FC Performance Audit Recommendations

Our 2007 report made several recommendations, including:

1. The Council identify ways to coordinate and align its current data collection and reporting requirements with national reporting initiatives, and conduct a major reassessment of its approach to adjusting hospital discharge data to account for differences in patient severity.

2. In conjunction with Recommendation 1, the Council should issue a Request for Proposal to secure an independent study to determine the cost to hospitals to comply with the Council's mandate for use of the MediQual Atlas System.

3. The Council should take steps to assure that all committee meetings are in full compliance with the state Sunshine Act.

4. The Council should adopt in full the Commonwealth Management Directives pertaining to contracting, travel, pay schedules, and personnel matters and expand on its interagency agreement with the Executive Branch to secure additional central administrative and oversight services, including legal services from the Office of General Counsel and internal financial and operations oversight from the Office of Comptroller Operations.

5. The Council should adopt the standards of the Governor's Code of Conduct for all members, including those not appointed by the Governor, and apply the Code to all staff.

6. The Council should form a second technical advisory group consisting of individuals with expertise in hospital discharge and payer data, and the General Assembly should provide for such a group in statute.

7. The Council should work with the General Assembly and the Governor's Office to assure that the consumer seat on the Council is filled.

Of these, the Council reported it has fully implemented numbers 1, 3, 6, and 7; partially implemented 4 and 5; and 2 is no longer applicable as Act 2009-3 and subsequent actions of the Council rendered the recommendation moot. We agree

with the Council's assessment with regard to the implementation status of these recommendations. The PHC4's detailed response to these and other recommendations made in our 2007 report is included in Appendix A.

With regard to PHC4's move from a third-party (MediQual) to an in-house risk adjustment methodology, the Hospital and Healthsystem Association of Pennsylvania stressed it was important to note the PHC4 sought and accepted stakeholder input throughout the transition process.

Visibility

Visibility to the Public

Media Exposure. In the 18 months from March 2011 through October 2012, the PHC4 was "in the news" at least 136 times (based on the PHC4's *In the News* website links). All but one was a Pennsylvania paper or television station, and the articles were in various newspapers from across the state. The exception was a national NBC News piece in July 2012 concerning the link between burned-out nurses and increased infections in patients. Many of the articles had to do with hospital finances, hospital acquired infections, preventable hospitalizations, and demand for joint replacements. A list of these items can be found on the PHC4 website under the tab *In the News*.[3]

PHC4 Website. The PHC4 has a website (www.phc4.org) that makes it easy to access their reports and other basic information about the Council and its functions. The PHC4 reported that its reports were downloaded 840,434 times in FY 2011-12.

PHC4 has also developed an Internet database of Medicare payments for common health care services, including colonoscopies, cataract surgeries, and MRIs. This information became available to the public in March 2011. For each county, the database provides the amount Medicare pays hospitals and ambulatory surgery centers for the listed services, along with the number of procedures the facility performed in a year. The database was designed to help consumers participating in high deductible health plans or who have no health insurance coverage at all to make the most efficient use of their health care dollars.

Questionnaire Comments. While, overall, the respondents to our questionnaires gave the PHC4 high marks, one area in which it did receive relatively low marks concerned public visibility, with 6 out of the 7 respondents responding to our

[3] PHC4 additionally reported that from January 2012 through July 2013 its reports had been cited in 72 newsclips, that the PHC4 or statistics it generated had been cited an additional 70 times, and 1 article had been written about PHC4.

interested parties questionnaire rating the Council's effectiveness towards public visibility as only "somewhat effective."[4] Comments/suggestions received included:

- Develop an open source portal with timely, longitudinal, machine ready down-loadable data integrated with a graphics interface to allow for rapid analysis. Data currently available to the public on the website are limited and dated.
- HC4 needs the authority and resources to provide real time data and to create value scatter graphs in accessible formats for consumers, physicians, and hospitals to use for decision-making and improvement.
- …. funding has been cut for so many years it is negatively impacting PHC4's ability to maintain operations and to effectively market its services and reports.
- It would be helpful if the PHC4 could increase promotions of the reports to the public. We receive a number of calls from consumers and we refer these folks to the PHC4 website, especially for the Hospital Effectiveness Reports. The majority of the individuals we speak with are not aware of the Pennsylvania Health Care Cost Containment Council or that there are free reports available.

Visibility to the Medical Community

HAP reported that hospitals are the heaviest users of PHC4 data, and the number of requests for PHC4 data (161 in the past 3 years) indicates that PHC4 has good visibility among the medical community. Unlike the responses we received regarding public visibility, all the respondents to our Interested Parties questionnaire rated the PHC4 as either "effective" or "highly effective" on the question regarding visibility to the medical community.

[4] We did not ask this question on the questionnaires to TAG and PDAG members.

III. Quality and Availability of PHC4 Data

To assess the quality and availability of the PHC4s data, we primarily relied on the providers (as represented by the Hospital and Healthsystems Association of Pennsylvania, the Hospital Council of Western Pennsylvania, and the Pennsylvania Ambulatory Surgery Association) and users of the data. We did not attempt to independently audit the accuracy of the data the PHC4 collects.

Data Providers. Both the Hospital and Healthsystems Association of Pennsylvania (HAP) and the Hospital Council of Western Pennsylvania reported that they found the data collected and reported by the PHC4 to be of high quality. HAP reported that it has used PHC4 data to help hospitals with problems they may be having with readmissions and that the Hospital Readmissions Report is a valuable tool for hospitals to use to monitor and address issues it may have with readmissions. HAP noted that hospitals have historically been the biggest users of PHC4 data and that they use the data to compare their quality to that of other hospitals. The Hospital Council of Western Pennsylvania also reported that the quality of the PHC4 data was good, but that it would be more effective if the data was more current.

The Pennsylvania Ambulatory Surgery Association held a much different opinion of the accuracy and usefulness of the PHC4 data,[1] noting:

> We view the reports as very inaccurate. The reports do not compare apples to apples. Because of the way in which the reports are configured, they do not show the real picture of the costs and profits of a surgery center, nor do they show the 'real' profitability of a hospital, even the non-profit facilities. The data requested is not in a format that parallels the ASC reporting systems and thus, there is a very loose manipulation of data to "fit the blanks" of the report. There is no true analysis of end of the year, after taxes are paid, etc. with all participating facilities.
>
> The quarterly data is even more invaluable than the end of the year reports. The PHC4 system is unable to accept the fact that many patients will not give their SSNs. Thus, there is an error rate that automatically occurs from all centers. The % of missing SSNs is growing each quarter. The rest of the errors are also insignificant [i.e., the errors are of little importance or not real errors]. The error summary will say there is an incorrect code used when in fact, the proper code was used, but the system filters do not match current coding edits. It

[1] Ambulatory surgery facilities report data to PHC4 on major ambulatory service, but not routine outpatient procedures.

> is time consuming to run these reports at the center level. We waste a tremendous amount of time making sure our systems can produce a report for PHC4 that has no value to those running ASCs. If we choose not to participate, our names are reported as non-compliant.

The PASA concerns appear to stem, at least in part, from differences between how hospitals report executive salaries (as expenses which are deducted from income) and how ASCs report distributions to owners (considered as part of profit). ASCs also report the PHC4 calculates the profitability of ASCs using pre-tax income and that other items, such as bad debt, are not classified or reported uniformly from facility to facility. As a consequence, ASCs can appear to be significantly more profitable than hospitals. For example, the PHC4 reported that 2011 operating margins, a key measure of profitability, were 25.02 percent for ambulatory surgical facilities but only 5.58 percent for general acute care hospitals. The ASCs are concerned about what they view as "apples-to-oranges" comparisons with hospitals because insurance companies have used PHC4 profitability reports as a reason to reduce payments to ASCs.[2]

With regard to the PASA's coding issues, the PHC4 reported that, as mandated in its act, it uses a data reporting format based the National Uniform Billing Committee (NUBC) UB-04 standard. This format is used primarily by institutions such as hospitals for inpatient and outpatient claims. This format is also used by ASCs, but not all ASCs. ASCs that do not use the UB-04 format would generally use the CMS 1500 format (which shares many of the data fields as UB-04), or no particular format in the case of cash-only freestanding facilities. PHC4 also noted that it has developed a free online tool that allows facilities to more easily report and correct their data. This tool has been available statewide since mid-2012. It can be particularly useful for facilities reporting smaller amounts of data, but it is also used by the largest facilities to correct data.

Finally, we spoke to HAP about the issue of obtaining Social Security numbers. HAP responded that, while this can be an issue for children and some patients, it has not be a significant concern for hospitals.

Data Users. Over the past three years, 161 individuals and organizations have paid amounts ranging from $150 to $83,000 to obtain PHC4 data and special data reports. PHC4 reported receiving total revenues of $647,865 in FY 2011-12 and $751,042 in FY 2010-11 from such sales. The requesters and the purpose of the request is published in the *Pennsylvania Bulletin* annually (a statutory requirement). The most recent listing (for data requests made in CY 2012) is included in Appendix B of this report.

[2] The PHC4 report on the financial status of ambulatory surgical facilities does point out these issues.

Requesters include hospitals and health systems (e.g., to obtain utilization and market share information for strategic planning purposes); insurers (e.g., to analyze network accessibility); academic and medical researchers (e.g., to identify the most effective prevention strategies and trends in lower extremity amputations); law offices (e.g., to verify facts discovered in pending hip replacement litigation); labor unions (e.g., to assess access, cost, and quality of care for their members); entrepreneurs (e.g., development of decision tools and benchmarking databases); public health agencies (e.g., to conduct research on the health impact of air pollution); and various state agencies such as the Auditor General (to audit hospitals that received tobacco funds), the Pennsylvania Patient Safety Authority, Department of Public Welfare, and the Pennsylvania Office of Attorney General.

While we were not able to determine the extent to which these data requests were specifically able to improve quality of care, help people gain access to or select providers, or hold down the cost of care, it is clear that many organizations find the data useful for a wide variety of purposes, many of which directly relate to issues regarding cost, quality, and access to care.

Our questionnaire to PHC4 data users also indicates the PHC4 data is viewed as a valuable resource. Of the 29 responses we received (out of 160 questionnaires sent), all 29 responded that the quality of the PHC4 data was either excellent (22) or good (7). When asked if they found the PHC4 data useful, 27 responded that the PHC4 data was either very useful (22) or useful (5). Two characterized the data as only "somewhat useful." Several respondents made suggestions for improving either the availability or quality of the data. Selected comments are shown in Exhibit 1.

Exhibit 1

Selected Comments Received Regarding the Value and Availability of PHC4 Data

- The data gathered by PHC4 have provided a unique opportunity for researchers to investigate not only the costs associated with healthcare but a variety of factors associated with improved patient outcomes.

- We have used the data in a few research projects, one of which has been published in *Health Affairs*. This paper has been widely cited since its publication in 2010. A second study using the PHC4 data is currently under consideration with Medical Care. This research would not have been possible without the PHC4 data.

- PHC4 data are vital in my research. In the past 5 years I've conducted numerous studies using PHC4 data, leading to substantial improvements in hospital care in the state. The Council is a huge asset to my research program and I wholeheartedly endorse its reauthorization.

- The data received from PHC4 is utilized to internally evaluate our current performance, our competitor's performance, and future opportunities. Through this data, we have the ability to not only illustrate current market share, but also utilize the data to enhance various other planning tools such as budgets and 5 yr. plans.

- We have published 2 articles using PHC4 data (PID hospitalization rates and TB hospitalization rates). Have another in preparation on visit rates for those with HBV, HCV, HIV mono- or co-infection.

- PHC4 data complements [our internal] data with external, all-payor data to see our experience in a larger context. In addition to the use of Request data, [our organization] makes extensive use of the online data as well.

- In addition to the discharge data our organization purchases quarterly, I personally have directed a number of people to the PHC4 website to look at hospital and physician based outcome data.

- The data and services provided by PHC4 to the healthcare industry and the general public will be ever more important with the implementation of the PPACA. PHC4 has been a pioneer in the movement toward transparency, accountability and quality within the healthcare sector.

- The hospital discharge data are critical to being able to maintain the quality of patient safety in PA inpatient settings.

- We use a third-party supplier (Databay) to purchase and format the data from PHC4 so it is easy to use. We use this data nearly every day.

- This data is mission critical to us to develop market forecasts of post-acute demand based on acute-care hospital volumes.

- If it would be possible for PHC4 to package NJ data in the same format as they do the PA data, that would be very valuable to us. NJ data is impossible to work with, and NJ DOH provides no real support.

- Reduce lag time in data/report availability.

- It would be very helpful to see patient charges at a revenue code level.

- Reduce the user fees.

Source: LB&FC questionnaire responses from PHC4 data users. Each comment is from a different respondent.

IV. Need for Reauthorization and Is There a More Cost-effective Way to Accomplish the Council's Objectives

In this chapter of the report we address (1) whether there is a demonstrated need for the Council and its functions and (2) whether there is a more cost-effective way for accomplishing the Council's objectives.

Is There a Demonstrated Need for the PHC4 Reports and Data?

To address this question, we reviewed how recent PHC4 data and reports have been received and used; input from Council members, advisory group members, and other interested parties regarding the continued need for the PHC4; and national and academic studies of health care cost and quality trends and the impact of data organizations such as the PHC4 on those trends. We also address the role the PHC4 may play in implementing the federal Affordable Care Act.

PHC4 Published and Special Reports

In addition to its annual Hospital Performance and Hospital Financial reports, PHC4 has issued several other more focused reports in recent years that have received positive comments from the health care community and wide-spread media coverage. These include:

Hospital Readmissions in Pennsylvania 2010. In April 2012, the PHC4 released a report detailing hospital readmission statistics from 2010 data. At the time of its release, HAP stated that the report is particularly noteworthy because April 2012 was the month the first group of Accountable Care Organizations (ACOs) began participating in the Medicare shared savings program. One of the quality measures on which health care providers participating in an ACO are evaluated is hospital readmissions. By the end of 2012, all Medicare providers were to be subject to the Hospital Readmission Reduction Program. "This report highlights an issue of critical importance to hospitals," said HAP President and CEO Carolyn F. Scanlan.

Highmark also cited the PHC4 work on hospital readmissions in its 2012 press release announcing that its Quality Blue program will require hospitals to focus on 30-day readmissions and that identifying admissions within 30 days of a previous hospital stay is an important overall measure of hospital quality.

Potentially Preventable Hospitalizations in Pennsylvania 2010. In June 2012, PHC4 released a report on Potentially Preventable Hospitalizations. Examples of media coverage of this report can be found under the *In the News* tab of the PHC4 website.

The Impact of Healthcare-associated Infections in Pennsylvania, 2010. PHC4 was one of the first agencies to issue public reports on the rates of hospital-acquired infections. It has followed up its original report with a series of reports on hospital and healthcare-associated infections, the most recent being in February 2012. The original 2005 report generated considerable attention and controversy, both in Pennsylvania and nationally, with some declaring the report as a watershed consumer guide and important spur to self-improvement among providers. Hospitals and physicians were generally more critical of the report, noting that the report was of limited usefulness because it did not separate the impact of the infection from the underlying disease or condition that may have brought the person to the hospital. In later reports, the PHC4 made some adjustments to address these criticisms.

Breast Cancer Surgery in Pennsylvania. In October 2012, PHC4 released a report on Breast Cancer Surgery in Pennsylvania in conjunction with Breast Cancer Awareness Month. Examples of media coverage of this report can be found under the *In the News* tab of the PHC4 website.

Special Reports. As noted in Chapter II, the PHC4 has received 161 requests for special reports. Appendix B lists the reports requested during CY 2012, and Exhibit 1 shows comments we received from the data requesters regarding the value of the PHC4 data.

Other Users of PHC4 Data

Pennsylvania Health Care Quality Alliance (PHCQA). The PHCQA is a voluntary coalition of Pennsylvania health care organizations, including hospitals, physicians, and health insurers, assembled to develop a common standardized approach to health care quality measurement.[1] PHCQA is an independent nonprofit organization, privately funded by the participating organizations with no direct financial support from the state or federal government.

The PHCQA compiles selected outcome and quality data from the federal Medicare program (CMS), the Pennsylvania Health Care Cost Containment Council, the Pennsylvania Department of Health, and the Joint Commission for Pennsylvania's general acute care hospitals in a single location with the goal of helping patients and consumers make better health care choices. By sharing aggregated quality performance data through public reporting on the Internet, PHCQA seeks to provide valuable, objective health care quality information for all consumers and identify and share best practices to improve the performance of all stakeholders.

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[1] Alliance participants include the Hospital & Healthsystem Association of Pennsylvania (HAP), which represents more than 225 hospitals and health systems across the state; the Delaware Valley Healthcare Council of HAP; the Hospital Council of Western Pennsylvania; the state's four Blue plans (Blue Cross of Northeastern Pennsylvania, Capital BlueCross, Highmark, Inc., and Independence Blue Cross); and the Pennsylvania Medical Society.

The PHCQA's Executive Director informed us that the PHC4 data is valuable to them, especially the cardiac and diabetes measures. However, PHCQA relies less on PHC4 data than in the past because they have been moving toward National Quality Forum-endorsed measures. NQF-endorsed measures are important because Medicare reimbursements are linked to performance on the NQF-endorsed measures. He also noted that PHC4 reports are often released about 2 years after the procedures occur (e.g., the PHC4 report on hospital readmissions was based on CY 2010 data, but not released until April 2012) and that this delay limits the usefulness of the reports.

We discussed the issue of NQF-endorsed measures with the Hospital and Healthsystem Association of Pennsylvania. HAP noted that hospitals report discharge information to PHC4, not specific quality measures, and that although PHC4's public reporting does not conform to NQF-endorsed measures, it does not cause more work for their members. HAP believes the PHC4 data repository is where the real value is for HAP and its members. HAP also noted that PHC4 data can be used to develop NQF-endorsed measures.

Pennsylvania Hospital Engagement Network (PA-HEN). PHC4 data is also being used by the PA-HEN to demonstrate improvement in hospital care over time. PA-HEN brings together hospitals with the Hospital and Healthsystem Association of Pennsylvania, the Pennsylvania Patient Safety Authority, and national, regional, and statewide quality and patient safety initiatives.

Informed Patient Institute (IPI). The Informed Patient Institute is an independent nonprofit organization whose mission is to facilitate access to credible online information about health care quality and patient safety. IPI does not rate individual health facilities or professionals. Instead, they assess the usefulness of various online doctor, hospital, and nursing home report card sites. Of the 14 physician websites reviewed in Pennsylvania, PHC4's cardiac surgery site was rated "very good" and was one of the top three sites listed. IPI gave PHC4 good grades for risk-adjusting its data and for offering information in a consumer-friendly database, but criticized it for having out of date information. IPI noted that when it reviewed the PHC4 in January 2013, the most current cardiac surgery data was from 2008-2009. IPI did not have comparative information for Pennsylvania for websites providing hospital report cards.

Patient Safety Authority (PSA). The Pennsylvania Patient Safety Authority, an independent state agency, is charged to take steps to reduce and eliminate medical errors by identifying problems and recommending solutions that promote patient safety in hospitals, ambulatory surgical facilities, birthing centers, and certain abortion facilities. Under Act 2002-13, these facilities must report what the act defines as Serious Events and Incidents to the Authority. The Authority then analyzes and evaluates the reports and makes recommendations for changes in health

care practices and procedures to reduce the number and severity of such events and incidents. A representative of the PSA is a member of the PHC4 Council, and the PSA occasionally uses PHC4 data in some of its reports and analysis.

Questionnaire Responses

Through our questionnaire, we asked the Council members, users of PHC4 data, and other interested parties whether they thought the Council should be reauthorized. Virtually all of the respondents (100 percent of the 13 Council members responding, 93 percent of the 29 data users responding, and 75 percent of the 8 interested parties responding) indicated they thought the Council should be reauthorized.[2] Selected comments are shown on Exhibit 2.

Evidence of PHC4's Impact on Health Care Costs and Quality

The primary concept of the PHC4 was to empower purchasers of health care benefits, such as business and labor union health/welfare funds, with information that could be used to improve quality and restrain costs. While it is possible that PHC4 data has helped to improve quality and restrain costs in some regions, overall Pennsylvania appears to perform no better in these areas than what would be expected based on national averages.

Pennsylvania Hospital Quality Performance Compared to National Averages. The Healthgrades[3] 2013 report on American hospital quality found that, as a whole, Pennsylvania hospitals rated only "average" in risk-adjusted in-hospital mortality rates during the three-year study period (2009-2011). Pennsylvania's hospitals, as a whole, performed statistically better in risk-adjusted mortality than the U.S. average in heart attack (7.2 percent vs. 7.4 percent), stroke (4.9 percent vs. 5.3 percent) and coronary interventional procedures (angioplasty/stent) (1.9 percent vs. 2.2 percent). However, Pennsylvania hospitals, as a whole, performed statistically worse in risk-adjusted mortality than the U.S. average in pneumonia (4.4 percent vs. 4.2 percent), respiratory failure (17.4 percent vs. 16.4 percent) and sepsis (17.6 percent vs. 17.3 percent).

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[2] Only one respondent thought the Council should be discontinued. Three did not answer the question.
[3] Healthgrades Inc. is a U.S. company that develops and markets quality and safety ratings of health care providers. According to their website, the 2013 report analyzed Medicare-patient care records for nearly 4,500 short-term, acute care hospitals nationwide, assessing hospital performance relative to each of 28 common conditions and procedures (cohorts). The Healthgrades methodology uses multivariate logistic regression to risk adjust for patient demographic and clinical risk factors that influence patient outcomes in significant and systematic ways.

Exhibit 2

Selected Comments Regarding PHC4 Reauthorization

- As we enter the Patient Protection and Affordable Care Act (PPACA) of health care, the Council can serve a pivotal role in providing objective data analytics and further transparency.
- The key to good public policy is good data, which PHC4 has been a recognized leader. PHC4 is a bargain for the Commonwealth at $3M and good public expenditure.
- There is a growing need to have timely and detailed information regarding health care costs and quality being delivered in the state.…The information the Council provides is essential to business who purchased the coverage for the employees and will continue to be more important to the individual seeking services since they will bear more of the cost burdens in the future.
- PHC4 is a unique resource which provides unbiased information to a broad range of constituencies across the state and beyond. While it is appreciated that many of these constituencies, especially the general public, may not make optimal use of the information, the improvements in hospital care and patient safety that result from public reporting can't be overstated.
- Council efforts have been beneficial in helping to reduce negative effects in the treatment of specific conditions by making comparative data available naming the provider.
- PHC4 is the gold standard for providing quality of care data by hospitals and physicians in PA and nationally. This information takes on added significance as we open the state exchanges in 2014.
- I would strongly support reauthorization. The need for an independent, verifiable database of payment data is more important than ever and its importance will continue to grow.…One of the ACA mandates is for non-profit hospitals to conduct Community Health Needs Assessment. Data such as what is produced by the PHC4 provides the necessary data to do this.
- It would be a great problem for consumers and providers of health care if this reauthorization did not occur. The cost and quality of health care remain a major issue in Pennsylvania.
- The Council should be definitely reorganized, it's just a shame most residents employers and unions do not take initiative to access and use.
- Reflecting our appreciation for the resources that PHC4 makes available, we have consistently and publicly supported reauthorization.
- The Affordable Care Act is making health insurance available to but does not necessarily support them in making better health care provider selections. PHC4 is a powerful source of impartial data and should be adequately funded and charged with providing better access to comparative data for consumers.
- Absolutely. It should be reauthorized. We need them and their services. We must tackle high health care costs and they are a key piece of that. Health care costs are on track to bankrupt the state and country.
- I've conducted numerous studies using PHC4 data, leading to substantial improvements in hospital care in the state. The Council is a huge asset…and I wholeheartedly endorse its reauthorization.

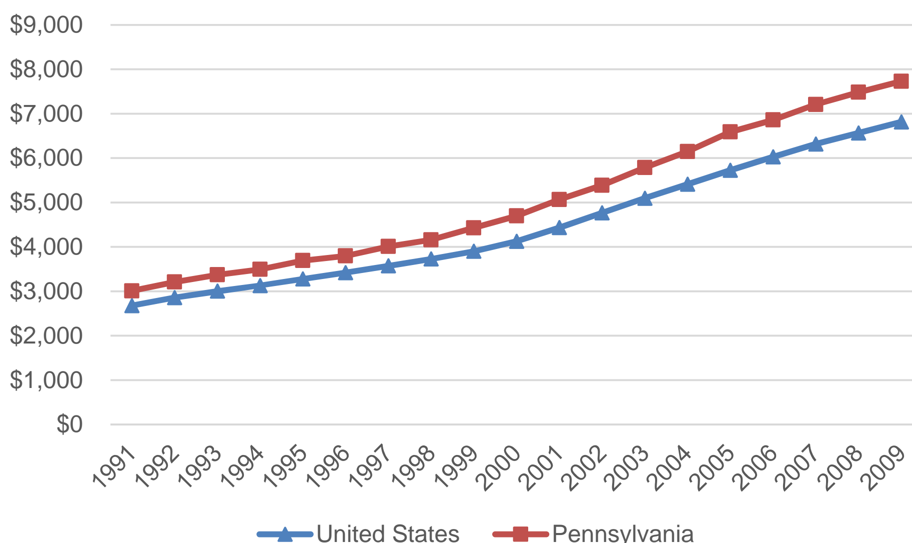
Source: LB&FC questionnaire responses. Each comment is from a different respondent.

Healthgrades also compared hospitals on 10 complication rate-based procedures and conditions.[4] Pennsylvania, as a whole, did not perform statistically better than the U.S. average in any of procedures and conditions studied during the period, and performed worse than the U.S. average in hip replacement (11.6 percent vs. 10.7 percent), total knee replacement (10.8 percent vs. 10.1 percent) and hip fracture treatment (26.9 percent vs. 25.2 percent).

Pennsylvania Health Care Costs Compared to National Averages. We also compared Pennsylvania health care cost trends to national averages. As Exhibit 3 shows, health care costs in Pennsylvania have closely tracked the national averages, though rising at a somewhat faster pace than the national average in more recent years.

Exhibit 3

Health Spending Per Capita in U.S. and Pennsylvania
(1991 – 2009)



Source: The Kaiser Family Foundation.

Academic Research on the Impact of Public Reporting of Health Care Data. Our review found mixed evidence regarding the degree to which public reporting of health care data promotes changes within health care. A 2012 Health Policy Brief[5] noted that, in general, consumers' use of public health reporting is low. A 2011 study of 16 community collaboratives found that websites comparing hospital

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[4] A hospital-acquired complication is any condition that arises while you are in the hospital that is unlikely to be related to your condition.
[5] *Public Reporting of Quality and Costs*, Julia James, Health Affairs, a publication funded by the Robert Wood Johnson Foundation. March 8, 2012.

performance were used primarily by consumers who were white, college educated, and over age 45. There was little use by vulnerable populations, and only about half of those visiting the sites indicated they were likely to use the data to choose a hospital. The Brief also cited a 2008 poll from the Henry J. Kaiser Family Foundation, which found that 30 percent of Americans said they saw information comparing the quality of different insurance plans, hospital, and doctors, but only 14 percent reported having used such information.

On the other hand, a 2008 study reported in the *American Journal of Medical Quality* found that patients treated at hospitals subjected to intensive public reporting (Pennsylvania hospitals were among those identified as having intensive public reporting under the PHC4) had significantly lower odds of in-hospital mortality when compared with similar patients treated at hospitals in environments with no public reporting or only limited reporting.[6]

PHC4's Potential Role in Implementing ACA

PHC4 envisions playing an important role in the development and monitoring of the federal Patient Protection and Affordable Care Act (ACA) in Pennsylvania, both through its participation in Pennsylvania's State Innovation Model grant and through the required and optional reports states will produce under the ACA.

Pennsylvania's State Innovation Model Grant. The CMS Innovation Center was established by section 1115A of the Social Security Act (as added by section 3021 of the Affordable Care Act) 42 U.S.C. §1315a. Congress created the Innovation Center to test "innovative payment and service delivery models to reduce program expenditures …while preserving or enhancing the quality of care" for those individuals who receive Medicare, Medicaid, or Children's Health Insurance Program (CHIP) benefits.

In early 2013, Pennsylvania received a federal grant of up to $1.56 million to develop a State Health Care Innovation Plan. Pennsylvania's proposed plan, as outlined to the federal Centers for Medicare and Medicaid Services (CMS):

> …builds upon current private and public sector payer and provider initiatives to advance new care delivery models and payment methodologies. The plan places strong emphasis on the need for innovative models on transitions of care, telemedicine and care management.
> Through the promotion of accountable provider entities responsible for population-based care, the state aims to develop a model that deploys community-based care teams to provide more appropriate services to

[6] *Reductions in Mortality Associated With Intensive Public Reporting of Hospital Outcomes.* Christopher S. Hollenbeak, Christopher P. Gorton, Ying P. Tabak, Jayne L. Jones, Arnold Milstein, and Richard S. Johannes.

> "super-utilizers" and enhance access to public health preventive services by better integrating the services into the provider community. The model will also motivate alignment of patient, provider, and payer interest through gain-sharing models. Infrastructure to support the model design will incorporate expanded health information technology to facilitate health record data sharing, advanced telemedicine services particularly in rural areas, and objective measurement of healthcare workforce data to make improvements to existing training.

The PHC4 anticipates working with the Insurance Department, Department of Health, and other state agencies in developing the information for this plan. The grant proposal is due to CMS by the end of September 2013, although it is possible that Pennsylvania will request that the deadline be extended. If CMS funding for the next round of funding is similar to the first round, Pennsylvania's grant award could be in the range of $50 million.

ACA Data Collection Requirements and Expectations. The ACA includes various provisions aimed at improving the quality of care provided by different types of health care professionals and providers. The legislation also directs the Secretary of the United States Department of Health and Human Services to develop a national strategy to improve health care quality. As part of this strategy, the ACA provides funding to develop quality measures to assess issues such as health care outcomes; functional status; transitions of care; consumer decision-making; meaningful use of health information technology, safety, efficiency, equity, and health disparities; and patient experience. The ACA also directs the Secretary of Health and Human Services to create a plan to collect this data and make it available to the public.

The initial set of measures was published in the Federal Register in January 2012. Fifty-one measures were identified in the areas of maternal/reproductive health, overall adult health, complex healthcare needs, and mental health/substance abuse. By September 2014, states will be required to submit these measures, and the results of the analysis will be made available to the public.

Although the ACA has elements that deal with nearly all of the key problems that drive the issues of access, cost, and quality of care, its primary focus is on increasing access to health insurance. The ACA is much less prescriptive in terms of improving quality and reducing costs. The expectation is that much of the innovation for making those improvements will happen within the states. One of the roles of a state-sponsored data organization is to provide data to support the innovations that will help improve the quality of state health care systems and reduce costs for consumers and businesses.

PHC4 reports it has already implemented programs to provide price transparency for a variety of services, especially inpatient admissions, which would further support one of the goals of the ACA: to reduce the information disconnect that currently exists regarding the actual prices of health care services. The agency's ongoing project of educating stakeholders about the relative price variation for inpatient services might also be expected to reduce that variation over time, making prices more competitive and standardized.

PHC4 noted several other specific examples of issues where its objectives align with the federal activities being implemented under the ACA:

Hospital Readmissions. Under Section 3025 of the ACA, payments to hospitals may be reduced for discharges on or after October 1, 2012, based on "excess readmissions" for certain applicable conditions (acute myocardial infarction, AMI; heart failure, HF; and pneumonia, PN). Under these payment rules, hospitals face penalties for certain types of (30-day) readmissions based on three years of preceding discharge data. Generally, the readmission payment penalty will be up to 1 percent for FY 2013 and up to 2 percent for FY 2014 of a hospital's Medicare base operating DRG payment.

Hospital Value-Based Purchasing Incentive Program. In addition to the readmissions penalty, for FY 2014 hospitals may receive an incentive adjustment of 1.25 percent of a hospital's Medicare operating base DRG. This amount is withheld from hospital reimbursement and then given back based on the hospital's performance for AMI, HF, and PN cases.

Hospital-Acquired Conditions (HAC) Penalty. Beginning in FY 2015 (October 1, 2014), CMS will implement a new program mandated by the ACA that will penalize the lowest 25 percent of hospitals in terms of performance on eight hospital-acquired conditions, as measured over a two-year period. As HHS/CMS' readmissions and incentive payment algorithms evolve over time, PHC4 will be uniquely positioned to inform both the public and technical discussion of these measures, especially in the context of how Pennsylvania providers are affected. As would be expected, many hospitals have a number of concerns about the new rules, not only from a payment, but also from a quality perspective.

The Council's Executive Director also notes that one of the most consequential components of ACA's health care reforms is the creation of state-based insurance exchanges, where individuals without coverage can shop for an insurance product at subsidized rates. He believes PHC4 would likely have access to exchange-based claims and clinical data in addition to data from all other payers, thus allowing it to acquire actionable data regarding the dimensions of health care services in Pennsylvania. In particular, this would allow the PHC4 to compare a number of important metrics involving outcomes and utilization based on coverage type,

plan features, and differential patient characteristics that could inform value-based benefit designs for health plans. With such data, the PHC4 believes it could provide research that would allow the citizens and policymakers of the Commonwealth to evaluate the performance and value of the federally-run exchange.

More Cost-effective Way to Achieve the Agency's Objectives

Fiscal Cutbacks

As shown in Table 1 and Exhibit 4, the amount appropriated to the PCH4 has declined significantly over the past six years, as has PHC4 staffing.

Table 1

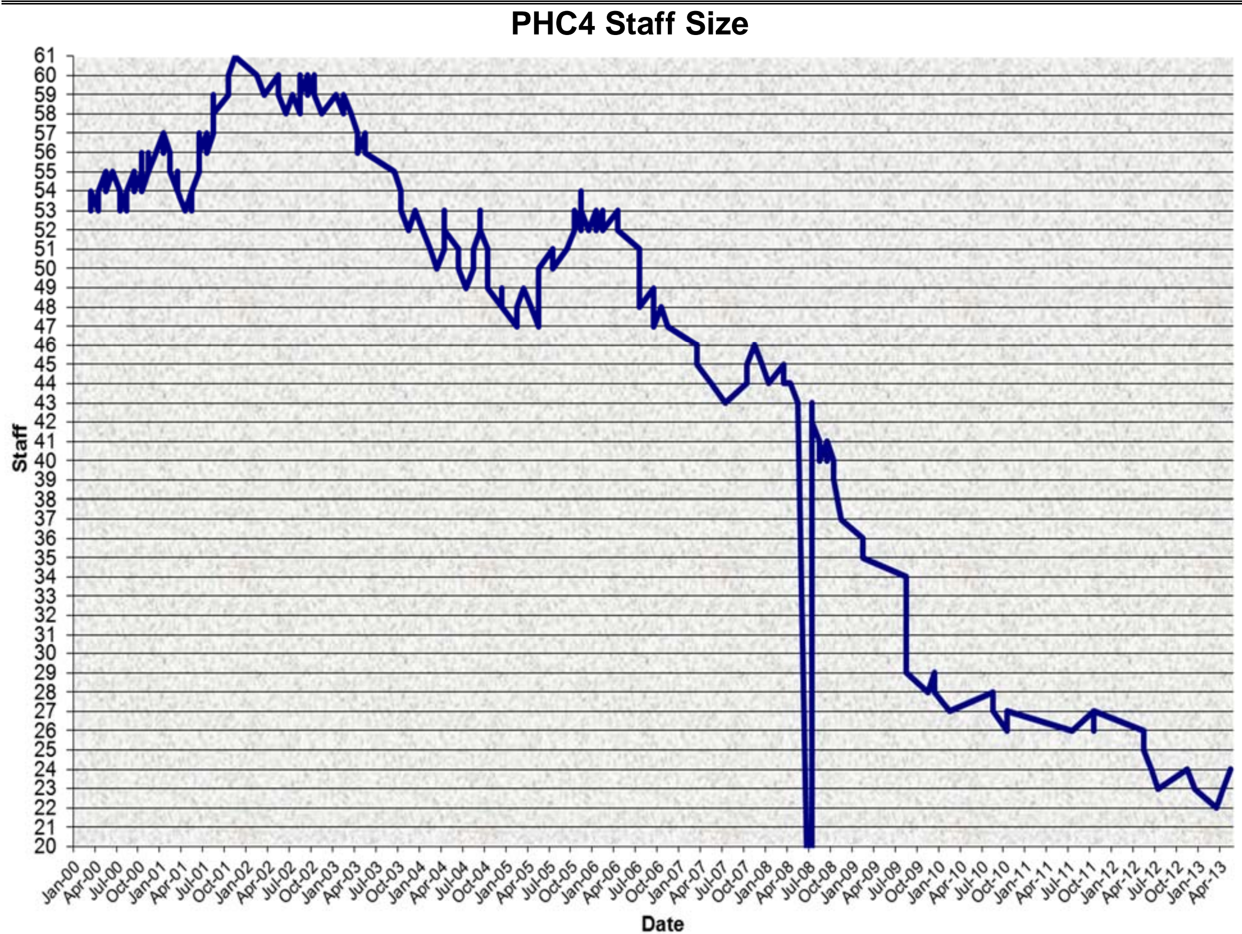
PHC4 General Fund Appropriations

Year	GF Appropriation (in Millions)
2007-08	$4.412
2008-09	3.753
2009-10	2.844
2010-11	2.710
2011-12	2.683
2012-13	2.683
2013-14	2.683

[a] The legislature appropriated $5.353 million for the PHC4. However, later in that fiscal year, Governor Rendell imposed a Nonrecurring Budgetary Freeze of $1.6 million. So the available line item was $3.753 million.

Source: Governor's Executive Budget Documents.

Exhibit 4



Note: The up and down dip in 2008 reflects the eight days PHC4 was without reauthorization in July 2008, when all staff were separated from service.

Source: PHC4.

To help maintain productivity in light of these cutbacks, the PHC4 reports it has invested in technology upgrades to streamline and modernize some of the activities that had previously been done manually. Some have commented, however, that these cutbacks are affecting the effectiveness of the agency:

- ….funding has been cut for so many years it is negatively impacting PHC4's ability to maintain operations and to effectively market its services and reports.

- PHC4 needs a larger budget to get the resources we need to fulfill our mission.

- Limited resources, combined with ongoing uncertainty over its status have, however, constrained its capacity to fully achieve its mandate.

- The degree to which HC4 is ineffective is directly related to the powers it is given and the funding it receives.

- They require funds for adequate staffing, funds to market and promote what they do and funds to redo the website.

Given these fiscal and staffing cutbacks, we considered it unlikely that, short of a major change in the scope of its mission, significant additional economies could reasonably be achieved.

Council Members. We asked Council members if they saw any opportunities for the Council to achieve its statutory objectives in a more cost efficient manner. Of the 13 members that responded, only one responded "yes" to this question.[7]

Merger With Department of Health. We reviewed the issues raised in the spring of 2012 when the Governor's FY 2012-13 Executive Budget proposed merging the PHC4 into the Department of Health. Several Senators expressed concern during the 2012 Senate budget hearing regarding the possible loss of the Council's independence if the PHC4 were to be merged into the Department of Health. Issues regarding the confidentiality of data and how the Council's funding could be assured were also addressed. The department acknowledged that "a number of hurdles" existed with this proposal, and stressed that the primary goal was to improve the flow of data between the PHC4 and the department.

The Council itself took no official action with regard to a possible merger with the Department of Health, but Council members generally appeared to oppose such a merger. When we discussed this issue with a DOH official in summer 2013, she indicated the department had no current plans to revive the merger issue.

Other Data Collection Entities. When PHC4 was first established in 1986, it was one of the first in the country to collect and report comparative data on the performance of specific hospitals. Now many organizations collect and report such data, including CMS (hospitalcompare.us), the Health Care Cost Institute, the Leapfrog Group for Patient Safety (created by employers), The Commonwealth Fund (www.whynotthebest.org), the Pennsylvania Health Care Quality Alliance, the Pittsburgh Regional Health Initiative, and others. These groups, however, are largely focused on providing "high level" consumer information to help individuals who are seeking information on how to decide which hospital to go to for a particular operation/procedure or employers seeking information to make health care insurance decisions for their organizations. None provide the risk-adjusted detail on

[7] This Council member explained his "yes" answer with the comment: Remove sunset provision as it is creating problems in hiring talented personnel.

specific cases (e.g., laboratory results) or the comprehensiveness of payers (commercial, Medicaid, and Medicare) or patients (all age groups) that are available through the PHC4.

The Pennsylvania *eHealth* Partnership Authority merits special mention because it was recently established in legislation (Act 2012-121) for the purpose of enabling the secure exchange of health information, primarily between health care providers such as doctors, hospitals, medical laboratories, and pharmacies. The Authority's goal is to provide leadership and invest in projects that will facilitate the use of electronic medical technologies so health care professionals can have a complete picture of a patient's medical records, thereby giving providers more informed and better choices in how they deliver care.

Pennsylvania was awarded $17.1 million under American Recovery and Reinvestment Act to help establish the health information exchange (HIE). The Authority envisions the HIE would operate under a "federated" model, where participants maintain their own information. Under this model, minimal centralization of data occurs, and no patient clinical information is stored within the community-shared services. As stipulated in Act 121, participation in the health information exchange by any health care provider, payer, consumer, or any other person is voluntary. The Authority also does not collect insurer payment information.

V. Issues for Legislative Consideration If PHC4 Is Reauthorized

Listed below are issues the General Assembly may wish to consider if it should decide to reauthorize the Council.

Authorize the PHC4 to Collect and Report Additional Outpatient Data Beyond Its Current Scope of Authority

PHC4 collects claims and payment data on health care services and procedures that require either inpatient hospital care or a major ambulatory service (defined, in part, as a service or procedure that requires special facilities such as operating rooms or special equipment not commonly found in physician offices).[1] PHC4 is not authorized to collect information on routine outpatient services provided by hospitals, ambulatory service facilities, or physician offices.

As shown on Exhibit 5, nationally, inpatient care comprises only about 22 percent of total health care spending. Moreover, outpatient care, which comprises more than 40 percent of overall health care spending, has been growing at a faster pace (7.5 percent per annum from 2003 to 2006) than any other category.

The Hospital and Healthsystems Association of Pennsylvania cited these trends in recent communications with LB&FC staff:

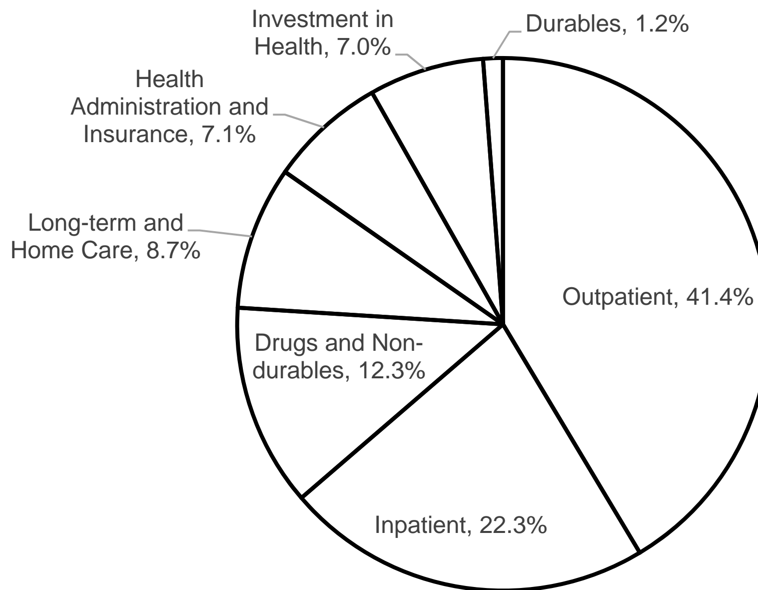
> Hospital utilization has been decreasing in recent years and now accounts for less than a third of health care spending. To ensure the continued relevancy of PHC4, it must broaden its scope of data collection and reporting to cover the continuum of care. In addition to continuing to collect discharge information from hospitals and ASCs, health care payers should be required to report all paid claims to PHC4 and that data should be leveraged to the greatest extent possible to enable and support health reform in the commonwealth.

The Pennsylvania Medical Society made a similar point, noting:

> As Society moves towards purchasing health insurance through public and private exchanges, the need for good data on both the inpatient and outpatient delivery sites is paramount. Providers cannot improve

[1] PHC4 is also authorized to collect data on any initial and follow-up outpatient services associated with the episode of illness before, during, or after the inpatient hospital care or major ambulatory service.

Exhibit 5



Source: *Accounting for the Cost of Health Care in the United States*, McKinsey and Company, January 2007.

> patient outcomes without actionable data. This data is not always available from the commercial insurance companies and the data that is available is specific to the claims processed by that particular insurance company. An all payer claims database would help to address such things as "outmigration" of patients from a community or health system. This data can be used by other governmental entities for things such as public health planning and to identify regional trends. This data can also be used to identify variation of outcomes from community to community.

The Act 3 Review Committee[2] similarly recommended as follows:

> The Review Committee recommends to the Pennsylvania General Assembly that new or amended legislation be considered to empower the Pennsylvania Health Care Cost Containment Council with expanded responsibilities and authority in order to address many or all of the issues raised in this report and to provide funding commensurate with the work...

[2] Act 2009-3 established a 15-member Health Care Cost Containment Council Act Review Committee to study and make recommended changes to the act. Their report was issued in June 2010.

Two of the issues raised in the report were the importance of the PHC4 collecting and reporting commercial and public insurance payment data and the need for additional information on outpatient treatments and services. As noted in the Committee's report, "Members of the Committee suggested it would be optimal to expand PHC4's legislative authority at some future point in order to analyze data sharing across systems of care rather than pockets of individual providers."

Finally, our questionnaire to PHC4 Council members asked to either agree or disagree with the following statement: *The Council's enabling legislation should be expanded to include reporting information beyond the inpatient and major ambulatory (outpatient) services setting.* Of the 13 members responding, 11 said they agreed with the statement. Only one Council member disagreed.[3]

Selected comments we received from Council members and others with regard to the PHC4 collecting additional data, particularly outpatient data, can be found in Exhibit 6.

Background on All Payer Claim Databases (APCDs).

Although there is no uniform definition of an all payer claim database, APCDs are generally defined as large-scale databases that systematically collect health care claims data from a variety of payer sources, including claims from most health care providers.[4] In 2008, the emergence of All Payer Claim Databases (APCD) were viewed as having the potential to help explain and "bend the cost curve" of rising health care costs by providing data that could be analyzed to understand the care delivery and cost patterns across health care settings. But their value would be limited if the 50 states did not use national standards for collecting the data from the payers. The APCD Council was formed to respond to this problem.[5]

The information typically collected in an APCD includes patient demographics; diagnosis, procedural and National Drug Code (NDC) codes; costs (including payer paid amounts and consumer liabilities); information about the type of service providers; and payer information (e.g., type of health plan). APCDs often include claims data from a full range of services, including primary care, specialty care, outpatient services, inpatient stays, laboratory testing, dental services, and pharmacy data, across multiple payers.

[3] One Council member responded "no opinion."
[4] Federal TriCare (military) and Department of Veterans Affairs claims are typically not included.
[5] The APCD Council's work is supported by The Commonwealth Fund, Academy Health's State Coverage Initiative, Agency for Healthcare Research and Quality, National Governor's Association, and with direct funding from UNH and National Association of Health Data Organizations.

Exhibit 6

Selected Comments Regarding the Need to Expand Collection of Outpatient Data

- Expand ambulatory data collection which is currently limited by statutory regulation.
- Need to explore the IT challenge for the PHC4 in order to deliver timely and more expanded reports related to cost and quality of care within the Commonwealth.
- Promote the reporting of *Episode of Care* cost and quality data and allow the Council to report using methodologies (i.e. ACO) that are increasingly being used as the basis for payment arrangements between private and governmental payers and provider organizations. Promote the reporting of physician and other health care professional services delivered in the office setting.
- Need to find a methodology or process to be able to report the insurance carriers payments to providers – hospitals and physicians.
- Begin to focus on quality and cost of physician and ambulatory surgery services.
- Expand beyond primarily inpatient data, since inpatient spending is a minority of total spend in today's environment.
- Include both inpatient and outpatient, especially for observation care services.
- Need to link outpatient and inpatient data; addressing topics that cut across care continuum.
- More authority and data from ambulatory and outpatient procedures.
- Across the U.S., the demand for and use of timely, transparent, all-payer healthcare quality, utilization and cost data is exploding – driven in important ways by the ACA.…Such a direction could expand the Council's relevance and impact enormously by putting more timely data in the hands of those working to improve health care costs and quality in Pennsylvania.
- Has there been any consideration in expanding the OP data that is gathered? With the shift from inpatient admissions to outpatient visits, having this data readily available as we do with the inpatient data provided by the Council, we will be able to evaluate ourselves given the industry shift.
- If you examine the ACA closely you will see that the main thrust of CMS is to push patients in lower cost settings and increase the quality of life of the patient. These goals require higher focus on measures and outcomes; neither of these groups of data are currently collected and reported on by PHC4. Tracking the episode will be even more critical to understand if the new care models are working. If you goal is to allow PHC4 to become relevant under the new health care reform, you must start addressing these issues.

Source: LB&FC questionnaire responses. Each comment is from a different respondent.

APCDs do not, however, contain clinical data from electronic medical records, laboratory systems, radiology systems, etc. So, although an APCD may contain claims from a laboratory test that was performed, it will not contain the results of that test. (The PHC4, in contrast, does collect the results of laboratory tests.)

While APCDs can provide information to help assess health care quality and access, the primary purpose of an APCD is to provide cost information. In particular, APCDs are used to document health care spending patterns and reveal diseases and medical treatment that "drive" health care costs in a state. APCDs can also identify opportunities for cost containment by revealing excessive or outlier claims by service, provider, and/or payer.

A number of states have designed their APCDs to improve price transparency by publishing prices for common procedures. The data generated by the APCDs enable consumers to understand, prior to having a procedure, the estimated price and how it could vary by health care provider.[6] This can be particularly valuable information for consumers who only have catastrophic coverage or might be self-pay. APCDs are also being used to monitor public health issues, provide insights on price disparities and quality issues, and help inform other health policies of interest to state officials.

HAP reports that data provided by APCDs can be used in many aspects of rate setting as well as Patient-Centered Medical Homes (PCMH). PCMH is a program for organizing and improving primary care. The data can also be used for trending analysis and risk contracting, such as for bundled payments and Accountable Care Organizations.[7]

APCDs in Other States

According to the APCD Council, 14 states are currently APCD states (Pennsylvania is not an APCD state).[8]

APCD states typically operate under a legislative mandate to collect insurance data. Some specifically detail the specific types of claim data to be collected (dental, pharmacy, etc.), while other states write their mandate more broadly. Insurers are required to participate in all but two of the APCD states. In these two states, Wisconsin and Washington, insurer participation is voluntary.

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[6] This type of comparative pricing information has been in practice in New Hampshire for several years.
[7] Accountable Care Organizations (ACOs) are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated care to their Medicare patients. If an ACO succeeds in both delivering high-quality care and spending health care dollars more wisely, it will share in the savings it achieves for the Medicare program.
[8] APCDs have not been fully implemented in all these states.

Public APCDs are typically funded by one or more of the following sources:

- General appropriations (e.g., New Hampshire).
- Fee assessments on public and private payers (health plans) and facilities (e.g., Vermont).
- Medicaid match (e.g., Utah).
- Data sales (e.g., Maine).

Uses of APCD Data

The APCD Council reports that states have APCD data to:

- develop a tiered-network insurance product for the small group marketplace (New Hampshire);
- provide cost information to support consumer-driven health care choices, providing information about the varying cost of procedures in different medical facilities (Massachusetts, New Hampshire, Maine);
- help employers understand variations in the cost and utilization of services by geographic area and in different provider settings (Maine, New Hampshire);
- explore the value equation (cost and quality) for services provided (New Hampshire);
- inform the design and evaluation plan of payment reform models including the medical home model and accountable care organizations (Vermont, New Hampshire);
- evaluate the effect of health reforms on the cost, quality, and access to care in a state (Vermont, Maryland);
- compare the prevalence of disease across a population (New Hampshire, Utah);
- compare utilization patterns across payers to inform state purchasing decisions for programs such as Medicaid (New Hampshire) and to identify successful cost containment strategies (Vermont, New Hampshire);
- determine payer competitiveness within the commercial insurance market (New Hampshire); and
- estimate the cost of potential legislative changes affecting health insurance and later calculate the actual cost.

In addition, Colorado's Center for Improving Value in Health Care (CIVHC) reports its APCD data will help address the concerns from the following constituencies:

Individuals. Facing higher out-of-pocket expenditures, they need better and more accessible information about the cost and quality of the care available to them. By the end of 2013, the APCD will provide specific information on the actual cost of common procedures and how various providers compare in cost, utilization and quality.

Employers (Purchasers). They want to see the cost of health coverage stabilize and get value for their, and their employees', premium dollar. And, more than ever, they want to have good data about provider quality to drive their purchasing decisions.

Clinicians. They want to understand how their cost, utilization, and quality compares to their peers so that they can continue to improve the care for their patients. The APCD will provide a comprehensive risk and severity-adjusted view of their performance relative to other providers across all insurers.

Health Care Policy Experts. They look for trends in cost and utilization, and meaningful ways to measure quality, in order to develop targeted policy interventions.

Health Care Finance Experts. They seek to understand where health dollars are spent and why, and the relationship between short-term investments and long-term health status.

Public Health Agencies. They want to understand the trends in disease diagnosis and treatment, and whether specific public education campaigns are followed by increased preventive services provided to patients.

Researchers. They want to explore the effects of investments in emerging technologies and interventions on the cost of care and the rate of hospitalizations.

Examples of some of the specific questions Colorado expects to be able to answer with the APCD include:

- Which part of the state has the highest obesity rate?
- Which procedures cost the most?
- Which hospitals have the lowest prices?
- What are the variations in cost for common procedures?
- What is driving Emergency Room visits?
- What is the average length of time people use antidepressant medications?
- Which facility charges the least for chemotherapy treatment?
- How far do people in rural areas travel for health care services?

More broadly, the CIVHC notes that:

> As transparency of cost and quality grows, it is expected that purchasers of health care services will go to those providers who provide the highest value. This same cost and quality data will also benefit providers and, for the first time, give them aggregated data that illuminates how their cost and quality compares to other providers. We feel the combination of this transparency will lead to improvement of quality and more competition on cost and quality performance.

Similar goals have been stated for APCDs in states such as New Hampshire, Massachusetts, and Minnesota.

Challenges to Establishing an APCD

The APCD Council reports that states implementing APCD reporting systems need to address multiple concerns, including:

Patient Privacy. Various approaches states are taking in response to privacy concerns include: not collecting direct identifiers, adopting encryption methodologies, and restricting the release of information that can directly or indirectly identify an individual patient. Some states, like Minnesota, will not permit the release of detailed data outside of the authorizing agency. States can impose penalties for misuse or inappropriate disclosures.

Payer Reporting Burden. APCD data collection and reporting is not without costs to those who must supply the data. A key advantage of using billing data from payers is that, by leveraging the claims reimbursement transaction system, payer and provider reporting burden is reduced. Because data are generated automatically for every medical encounter in a standardized format, the use of existing data minimizes reporting costs.

To the degree that states adopt a uniform reporting format, national payers will not bear the compounded costs of responding to unique state reporting requirements. States are working with the National Association of Health Data Organizations (NAHDO), the Regional All-Payer Healthcare Information Council (RAPHIC), and America's Health Insurance Plans (AHIP) to harmonize their collection requirements to align with payer capabilities.

To date, the APCD Council reports it has been unable to obtain any specific cost information from the carriers regarding their cost of supporting APCDs. It also notes that efforts between the APCD Council and the industry have led to data standardization, which should help minimize payer costs. The director of the Massachusetts APCD reported that, although he did not have exact figures, he thought it likely

that insurers have spent "millions" to develop reporting systems to meet Massachusetts' APCD requirements.

Data Use and Access. Most state APCD programs make the information available in various formats for external and internal users. Though most states have a long history of reporting hospitalization data, in some states the APCD data set has posed unique challenges, largely because it includes payment information. To overcome those challenges, states aggregate and protect proprietary and other sensitive information. To increase stakeholder support and trust, the APCD Council recommends states develop a consensus plan on data uses to support public statistics, health services, and public health research.

ERISA. The Employee Retirement Income Security Act of 1974 (ERISA) is a federal law that sets minimum standards for most voluntarily established pension and health plans in private industry as a way to provide protection for individuals in these plans. ERISA also preempts all state laws that relate to any employee benefit plan, with certain exceptions. An official with the New Jersey Department of Banking and Insurance cited concerns over the ERISA preemption, especially given the large number of ERISA employers in their state, as one of the factors in their decision not to seek federal funds to establish an APCD in New Jersey.

The APCD Council informed us, however, that all APCD states are currently collecting ERISA data. Additionally, a Vermont federal court recently dismissed a suit filed by an insurer claiming that ERISA preempts the state's APCD authority. According to one attorney familiar with the case, the court, in essence, cites the "presumption against preemption" that exists when a state attempts to regulate "health and safety matters."

Governance. States have adopted several approaches to governance of an APCD system, with various advantages and disadvantages. We assume that should an APCD be established in Pennsylvania it would be under the jurisdiction of the PHC4.

Costs. Costs to establish and operate an APCD vary depending on a variety of factors, including:

- State health care system market structure (e.g., the numbers and types of delivery systems that are present in the state).
- State population (e.g., covered lives) and insurance coverage patterns (e.g., the types of health insurance products in place for the population).
- Number of licensed payers, including TPAs (third party administrators) and PBMs (pharmacy benefit managers), and the number of data systems in place for those payers (e.g., many payers have multiple transaction systems housing the data).

- Location of the agency where the APCD is to be housed (e.g., insurance department, health department, or other type of arrangement such as a state-sponsored private entity).
- Administrative structure (e.g., using in-house staff or a contracted third-party vendor).
- Planned users and uses for the APCD and associated costs of data release (e.g., if researcher access is planned).

Pennsylvania, perhaps more so than in the current APCD states, would face major administrative challenges in developing an APCD due to the size and complexity of the Pennsylvania health care marketplace. Of the ten states that have implemented a mandatory APCD, all have significantly smaller populations than Pennsylvania, with half (Kansas, Maine, New Hampshire, Utah, and Vermont) having populations of less than three million. The most populous APCD state, Massachusetts (6.6 million), is only about half the size of Pennsylvania (12.7 million). Massachusetts also has only one Blue Cross/Blue Shield plan and 81 general acute care hospitals, compared to Pennsylvania's four BC/BS plans and 158 general acute care hospitals.

The administrator of the New Hampshire APCD noted that insurers typically provide APCD data in "raw" form, and it requires a complex and time-consuming effort to transform this raw data into a format that can be used and understood by the public. He noted that, among other issues, provider identification numbers change frequently, that physicians may practice alone or in one or more different physician groups, and that a physician group may be part of a larger physician group or hospital. Rolling up this raw data so that it is useable requires an understanding of the circumstances of the various practices and, according to the New Hampshire administrator, is the single largest challenge APCD organizations face.

Funding. The APCD Council reports that in states that have mandated reporting, funding often comes from either general funds and/or mandatory fees from providers or insurers.[9] Voluntary APCD programs are usually funded through membership fees and/or grants and contracts. Both mandatory and voluntary programs can also expect some degree of revenue from data product sales once the system is operational.

Federal grants and funding are also available. As noted above, Pennsylvania has already received a federal State Innovation Model grant to design a State Health Care Innovation Plan. If accepted, Pennsylvania could receive funds in the range of $50 million to implement that plan. At least some of those funds could be used to establish a more comprehensive database.

[9] In Maine, for example, revenues are derived from fees assessed on hospitals (based on net patient service revenue), carriers (based on premiums), and from TPAs (based on claims paid for plan sponsors).

States are also eligible to receive a total of $87 million in federal Center for Consumer Information & Insurance Oversight (CCIIO) Rate Review Cycle III grants that could be used to establish an APCD. CCIIO/CMS plans to make 50 awards, with grants ranging from $500,000 to $5 million. The Funding Opportunity Announcement (FOA) released in May 2013 specifically mentions state level examples of price transparency from the New Hampshire, Vermont, and Maine APCDs. The FOA also noted that states applying for Cycle III funds only to establish a data center do not "need to demonstrate that it has or will meet the criteria for an effective rate review program...." At least one state (Utah) has been able to use Medicaid federal match funding to partially support APCD development.

APCD Model Legislation

The Catalyst for Payment Reform and the Health Care Incentives Improvement Institute have developed an APCD model bill for states to consider.[10] The model bill requires the establishment of a public database on health care price and quality, primarily by instituting an all-payer claims database.

In Section 2, the model bill requires the establishment of a public database on health care price and quality, primarily by instituting an all-payer claims database.[11]

Section 3 addresses the need of the general public for directionally accurate information on the price of health care services in a state if individual consumers are self-insured or uninsured or if they are insured through a health plan but contemplating going out-of-network for services. Some of that information can come from a hospital or practitioner when dealing with a direct inquiry from a consumer. This will ensure that all consumers are provided charging information from a provider of health care services up front, not after the fact.

Section 4 requires health plans to be responsible for providing estimated out-of-pocket expenses for common inpatient discharges and outpatient procedures (e.g., a knee ligament repair), not simply specific services (e.g., a blood test or X-ray). This is important because there are many services involved in a medical event and, without an estimate from the health plan on the cost of the full event, there is virtually no way for consumers to put the pieces together and understand their potential financial liability. Health plans are also obligated to give their plan members information on quality of care based on recognized national quality standards.

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[10] The model bill is available by contacting the LB&FC offices.
[11] See http://www.apcdcouncil.org/standards for standards on data elements recommended for inclusion in an APCD.

Current Status in Pennsylvania

The PHC4 Payment Data Advisory Group has been developing a process by which insurance payment data can be collected, analyzed, and reported given PHC4's current statutory authority. As noted by one PDAG member representing the business community:

> There is a relative lack of information about the payments made for various treatments and procedures. Knowing the average payments made for different services and procedures by payers could begin to fill the current "information gap." Having such data available could be useful in designing high performance networks where employee cost-sharing might vary depending on the relative provider costs of various treatments.

The PHC4 reports it has used the national template developed by the APCD Council to collect one year (2010) of inpatient hospital payments and that they are currently testing and verifying the results before requiring health plans to submit additional data.

In FY 2013-14, the PHC4 staff intends to work with the PDAG in moving the Commonwealth towards more comprehensive and increasingly specific reporting initiatives within its current authority, including the examination of per capita cost for high risk, high cost treatment areas such as chronic disease management. PHC4 believes this will help the Commonwealth and its various health care stakeholders better understand, through initial benchmarking and subsequent measurement, whether efforts made and resources committed to improvements in quality care and costs restraint in these "hot spots" are effective and, if so, to what degree.

PHC4 currently plans to limit its data collection efforts to only those inpatient and outpatient services for which it is authorized to collect data under its enabling legislation. The PHC4 believes the combination of its existing inpatient/outpatient database with a payer database that includes Medicare, Medicaid, and commercial insurance payments would put the Commonwealth in a strong position to strategically monitor and improve health care delivery.

Position of Pennsylvania Insurers

As Pennsylvania's insurers would be integral to establishing an APCD, we sought their input on concerns they might have about providing the claims data necessary to support such an effort. All four of Pennsylvania's Blue Cross/Blue Shield plans and the Insurance Federation of Pennsylvania (representing commercial insurers) reported they were opposed to Pennsylvania becoming an APCD state.

The insurer concerns centered on sharing proprietary data with health care providers and insurance competitors; privacy and security; the value of the data collection proposed under APCD to help control costs, improve the quality of care or better educate consumers of health care insurance; and the cost to provide the data, particularly given the numerous new quality reporting initiatives contained in the Affordable Care Act.

More specifically, Pennsylvania's insurers are concerned that access to payment data could lead to increased health care costs. For example, two insurers informed us of separate situations where, once a hospital learned it was receiving a lower reimbursement than another hospital in the insurer's network for the same procedure, it was able to use this information to negotiate higher reimbursement.

Another insurer noted that, as every negotiation and situation is unique, it would be extremely difficult to try to compare the cost at one hospital to another. For example, a hospital may prefer being paid more for cardiology-related procedures in a new heart wing and be willing to accept less for general surgery as an indication that their investment is paying-off. Such information could be used by providers to try to cherry pick various procedures, demanding more for this treatment but be unwilling to accept less for another in which their competitor is reimbursed less. This insurer also noted the importance of insurance competition and that they do not wish to share their negotiated rates with any of the insurers who sell coverage in their region.

Colorado's Center for Improving Value in Health Care addressed some of these issue as follows:

> *What if providing transparent prices actually encourages hospitals and physicians with lower costs than their peers to raise their rates?* That's certainly a potential unintended consequence. Experience in other states, however, demonstrates that purchasers and consumers migrate toward the providers who demonstrate high quality and low costs in the APCD—we've seen that happen in Massachusetts, for example, as consumers have used the data in that state's APCD. And when consumers vote with their feet and their checkbooks in that fashion, other providers don't want to miss out. They look for ways to change the way they provide care in order to improve quality and lower costs.

Another insurer expressed concern that if an individual learns, for example, that one hospital receives a higher reimbursement for a particular procedure than another hospital, he or she may automatically assume that the hospital receiving the higher reimbursement is the better facility. The individual may then seek to have their procedure done at the higher cost, but not necessarily higher quality, hospital.

Insurers also voiced concerns about privacy and security with regard to requiring payers to submit sensitive claims-related data such as social security numbers and diagnosis; the value of claims-only information given the complexity of provider reimbursement agreements and the possibility such information could be misconstrued by the public, providers, and other insurers; and that the Commonwealth and all stakeholders would be better served by improved coordination between the various existing data collection and health care quality reporting initiatives such as the *eHealth* collaborative health information exchange (HIE) and the State Innovation Model (SIM) initiative.

The Insurance Federation cautions against any expansion of data collection without a comprehensive cost/benefit analysis and a thorough review of the existing data available to the PHC4 and how it might better serve Pennsylvania consumers by analyzing and making the information available in a more user-friendly manner. The IFP believes there are more efficient sources of data already available to the Council, and that embarking on a massive expansion of data collection would be a needless cost on insurers and our policyholders without a corresponding unique value. The IFP encourages the consideration of alternative data collection efforts, particularly the use of Health Care Cost Institute (HCCI) as an alternative to the APCD program.

Eliminate the Requirement for Certain Reports and Studies

The Hospital and Healthsystem Association of Pennsylvania (HAP) believes the PHC4 enabling legislation contains antiquated responsibilities that could be eliminated. Two provisions that HAP specifically cites are the requirement that PHC4 conduct studies on indigent care and mandated benefits reviews.

Indigent Care Studies

Under §8(b) of the Health Care Cost Containment Act, at the request of the Governor or General Assembly, the PHC4 is to conduct studies on the costs and most appropriate means of providing indigent care. The PHC4 conducted an indigent care report in 1988, but has not been requested to conduct, and has not conducted, a subsequent report. HAP notes that access to care for the uninsured was a major focus for PHC4 when it was first created in 1986. 1986 was also the year Congress enacted the Emergency Medical Treatment and Active Labor Act, which requires hospitals to provide care to anyone needing emergency health care treatment regardless of citizenship, legal status, or ability to pay. This act largely eliminated the initial concerns embodied in this provision of the act. HAP further notes that as the Affordable Care Act of 2010 is fully implemented, the number of uninsured in Pennsylvania should decline.

Mandated Health Benefits

Under §9 of the Health Care Cost Containment Act, upon the request of appropriate committee chairs of the House and Senate or upon the request of the Secretary of Health, the PHC4 is to provide information on proposed mandated health benefits. The PHC4 has done 22 such reports, but none since 2008. HAP reports that these types of reviews in the past have drained Council resources, delayed the public policy making process, and have had little or no influence on the adoption or rejection of specific mandated benefits.

While our 2007 sunset report on the PHC4 did not specifically address the effectiveness of the mandated health benefit provision, we did find that of the 18 mandated benefit reviews the PHC4 conducted between 1998 and 2006, PHC4 only recommended a Mandated Benefit Review Panel be convened for one. (The Council's role in conducting mandated benefits reviews is primarily to conduct a preliminary review to determine if sufficient evidence is available to proceed to contract with a formal Mandated Benefit Review Panel.) And in this instance, the panel never met because the General Assembly acted on the proposed legislation before the panel could be convened.

The PHC4 did convene a Review Panel in 2008 regarding HB 1150, pertaining to insurance for autism spectrum disorders. The Panel's report, which was favorable toward the legislation, was released on June 18, 2008. The bill subsequently passed the House on July 2, 2008, and the Senate on July 3, 2008. Although difficult to know with certainty, the Panel's report does not appear to have affected the outcome of the legislation as HB 1150 was well toward passage when the report was released.

PHC4 estimates that if a preliminary review indicates it should proceed with a formal Mandated Benefit Review Panel, it could incur costs in excess of $100,000 for one such report.

Other Reports/Studies

We also found several other areas in which PHC4 has been legislatively charged to conduct studies but has not done so, at least not in recent years:

Annual Reports. Under §5(d)(10) of the act, PHC4 is to issue annual reports to the General Assembly on the rate of increase in the cost of health care in the Commonwealth, the effectiveness of the Council in carrying out the legislative intent of the act, the quality and effectiveness of health care, and access to health care for all citizens of the Commonwealth. To some extent the Council addresses these mandates by issuing annual reports on the financial health of Pennsylvania's general acute care hospitals and ambulatory surgery facilities, annual reports on the

performance of hospitals and ambulatory surgery facilities using risk-adjusted data, and an annual report on Council activities. These reports do not, however, address the rate of increase in the cost of health care or the quality and effectiveness of health care in areas other than hospitals and ambulatory surgery facilities, nor do they address the issue of access to health care.

Noninpatient, Alternative Delivery Systems. Under §5(d)(12) of the act, the PHC4 is to conduct studies and publish reports analyzing the effects that noninpatient, alternative health care delivery systems have on health care costs. These systems PHC4 is to review include, but are not limited to: HMOs, PPOs, primary health care facilities, home health care, attendant care, ambulatory service facilities, freestanding emergency centers, birthing centers, and hospice care. The PHC4 reports on the financial status of ambulatory surgery facilities, but draws no specific conclusions on the effect they have on health care costs. PHC4 has also issued reports on the quality of commercial HMO, but has not released a new HMO report since April 2008 (covering 2006).

Experimental and Nonexperimental Transplants. Under §5(d)(13) of the act, the PHC4 is to conduct studies and make reports concerning "the utilization of experimental and nonexperimental transplant surgery and other highly technical and experimental procedures, including costs and mortality rates." The PHC4 reports it has not conducted any studies under this provision since 1994.

HAP supports the elimination of the study requirements regarding mandated benefits, indigent care, and transplants. HAP believes the requirement for noninpatient, alternative care studies should be retained, however, especially in light of the possibility that the PHC4 might be expanded to include APCD outpatient data.

Other Issues Raised

Other issues raised during this study pertaining to PHC4's enabling legislation included:

Sunset Termination

We asked Council members whether they thought the Council should continue to operate under sunset termination dates (the PHC4 was subject to sunset in 1992, 2003, 2008, and, currently, 2014). Most (8 of 13) Council members thought the Council should continue to be subject to periodic (every 5 or 10 years) sunset review, but others believe that sunset review is unnecessarily disruptive. Comments from those who opposed continued sunset reviews included:

- Sunset review implies a temporary need for the data analytics capabilities of the Council. That may have been justified in original legislation, but no

longer. The review process is simply a distraction from the larger mission of the Council.

- PHC4 has proven its worth over the last quarter century plus. The sunset provision should be eliminated as it is making it very difficult to attract and retain the talent we need to do our work and meet our objectives.
- Too many disruptions at the cost of staff morale.

Council Membership

Pennsylvania's SMC Business Councils[12] support the reauthorization of the PHC4, but believe the Council should be expanded to include representation from small business. The SMC commented:

> Small businesses, unlike their larger business counterparts who self-insure, have little access to price and quality information. PHC4 membership should be modernized to give a voice and adequate representation to small employers.
>
> One of the practical ways to constrain health care costs is through the use of consumer-directed high deductible plans. These plans are growing in popularity among small businesses and the self-employed. Individuals are incentivized to shop for the best value in health care by comparing providers' quality, service and prices. Prices charged by providers for MRIs, mammograms and even X-rays can vary by as much as 300 percent, but it's virtually impossible for consumers to find this out.
>
> Unfortunately, small employers and individuals, who have the most to gain from transparency, do not have access to the type of price and quality information available to large, self-insured groups. Small employers, rather than large businesses and labor unions, should have a seat at the PHC4 table.

Reporting on Insurers

The Hospital Council of Western Pennsylvania commented that it would be helpful if PHC4, perhaps in partnership with the Department of Insurance, could take on the additional role of collecting and reporting benchmark data on public and private health insurers, especially given the new model of insurance exchanges.

[12] Representing small manufacturers.

VI. Background

The Pennsylvania Health Care Cost Containment Council is an independent state agency formed to collect, analyze, and make available to the public data about the cost and quality of health care in Pennsylvania.

On a quarterly basis, the Council collects approximately four million inpatient hospital discharge and ambulatory/outpatient procedure records annually from hospitals and freestanding ambulatory surgery centers. The Council uses this data to prepare reports on health care quality and costs in Pennsylvania.

Legal Background

The Health Care Cost Containment Act, Act 1986-89, as amended, 35 P.S. §449.1 et seq., created the Health Care Cost Containment Council to "promote health care cost containment," to "promote the public interest by encouraging the development of competitive health care services in which health care costs are contained," and "to assure that all citizens have reasonable access to quality health care." The act further intends to:

> facilitate the continuing provision of quality, cost-effective health services . . . by providing current, accurate data and information to the purchasers and consumers of health care on both cost and quality of health care services and to public officials for the purpose of determining health-related programs and policies and to assure access to health care services.[1]

To achieve its goals, the Council makes available information such as comparisons among providers of payments received, charges, population-based admission or incidence rates, and provider service effectiveness for various DRGs adjusted for patient severity. The Council is also charged to conduct reviews of proposed mandated health benefits and to study the problem of indigent care within the Commonwealth.

The original PHC4 legislation established a sunset date for the Council of December 31, 1992. The General Assembly reauthorized PHC4 in 1993, with a sunset date of June 30, 2003. The Council was reauthorized in 2003 through Act 2003-14, which established a new sunset date for the Council of June 30, 2008. However, the PHC4 was not reauthorized until June of 2009 (Act 2009-3). During this time, PHC4 operated under an Executive Order issued by Governor Rendell in July 2008 and again in November 2008. Act 2009-3 established the new sunset date for the PHC4 as June 30, 2014.

[1] 35 P.S. §449.2.

Powers and Duties

The Council has many specific powers and duties. In general, according to the act the Council is to:

- Develop a computerized system for the collection, analysis, and dissemination of data.
- Establish a Pennsylvania Uniform Claims and Billing Form for all data sources and providers.
- Collect and disseminate data as specified in the act, and other information from data sources (e.g., hospitals, physicians, certain health care facilities, etc.) prepared according to formats, time frames, and confidentiality provisions specified in the act and by the Council.
- Adopt and implement a methodology to collect and disseminate data reflecting provider quality and provider service effectiveness.
- Issue special reports and make available raw data to any purchaser requesting it.
- Publish annually in the *Pennsylvania Bulletin* a list of all the raw data reports it has prepared, a description of the data obtained through each computer-to-computer access it has provided, and the names of the parties to whom the Council provided the reports or the computer-to-computer access.
- Promote competition in the health care and health insurance markets.
- Assure that the use of Council data does not raise access barriers to care.
- Make annual reports to the General Assembly on the rate of increase in the cost of health care in the Commonwealth and the effectiveness of the Council in carrying out the legislative intent of this act. Also, make annual reports to the General Assembly on the quality and effectiveness of health care and access to health care for all Commonwealth citizens.
- Conduct studies and publish reports that analyze the effects noninpatient, alternative health care delivery systems have on health care costs. These systems include, but are not limited to HMOs, PPOs, primary health care facilities, home health care, attendant care, ambulatory service facilities, free-standing emergency centers, birthing centers, and hospice care. These reports shall be submitted to the General Assembly and be available to the public.
- Conduct studies and make reports concerning the utilization of experimental and non-experimental transplant surgery and other highly technical and experimental procedures, including costs and mortality rates.

- Develop and implement outreach programs designed to make its information understandable to purchasers, providers, state agencies and the general public.

Other sections of the statute define in greater detail the manner in which the Council is to perform these duties and functions.

Council Composition

The Health Care Cost Containment Council is an independent agency consisting of 25 members including the Secretary of Health, the Secretary of Public Welfare, the Insurance Commissioner, six representatives of the business community, six representatives of organized labor, one representative of consumers, two representatives of hospitals, two representatives of physicians, one representative of the Blue Cross and Blue Shield plans, one representative of commercial insurance carriers, one representative of health maintenance organizations, one individual who has expertise in the application of continuous quality improvement methods in hospitals, and one representative of nurses. The representatives of the business community and organized labor are appointed by the Speaker of the House and President Pro Tempore of the Senate. The remaining members, excepting the Cabinet members, are appointed by the Governor.

Members annually elect a chairperson and vice chairperson from among the business and labor representatives on the Council. Thirteen members, at least six of whom in any combination shall be made up of representatives of business and labor, constitute a quorum for transacting business.

The Council is required to meet at least once every two months. Members do not receive a salary or per diem allowance but do receive reimbursement for actual and necessary expenses that they incur.

Council members are eligible to serve two full consecutive terms of four years. Cabinet members serve terms running concurrent with their holding of public office. Members may be removed for just cause after recommendation by a vote of at least 14 members.

Recent Amendments

Act 2009-3 amended the Health Care Cost Containment Act in several important ways. Most significantly, it prohibits the Council from contracting with any specific vendor for data collection, a significant source of concern during the PHC4's 2008 sunset review.

Act 3 also created the Payment Data Advisory Group to produce recommendations surrounding the collection and reporting of payment data and the Health

Care Cost Containment Council Act Review Committee, which was charged to study and make recommendations for changes to Act 3, including a methodology for the Council to risk-adjust quality data.

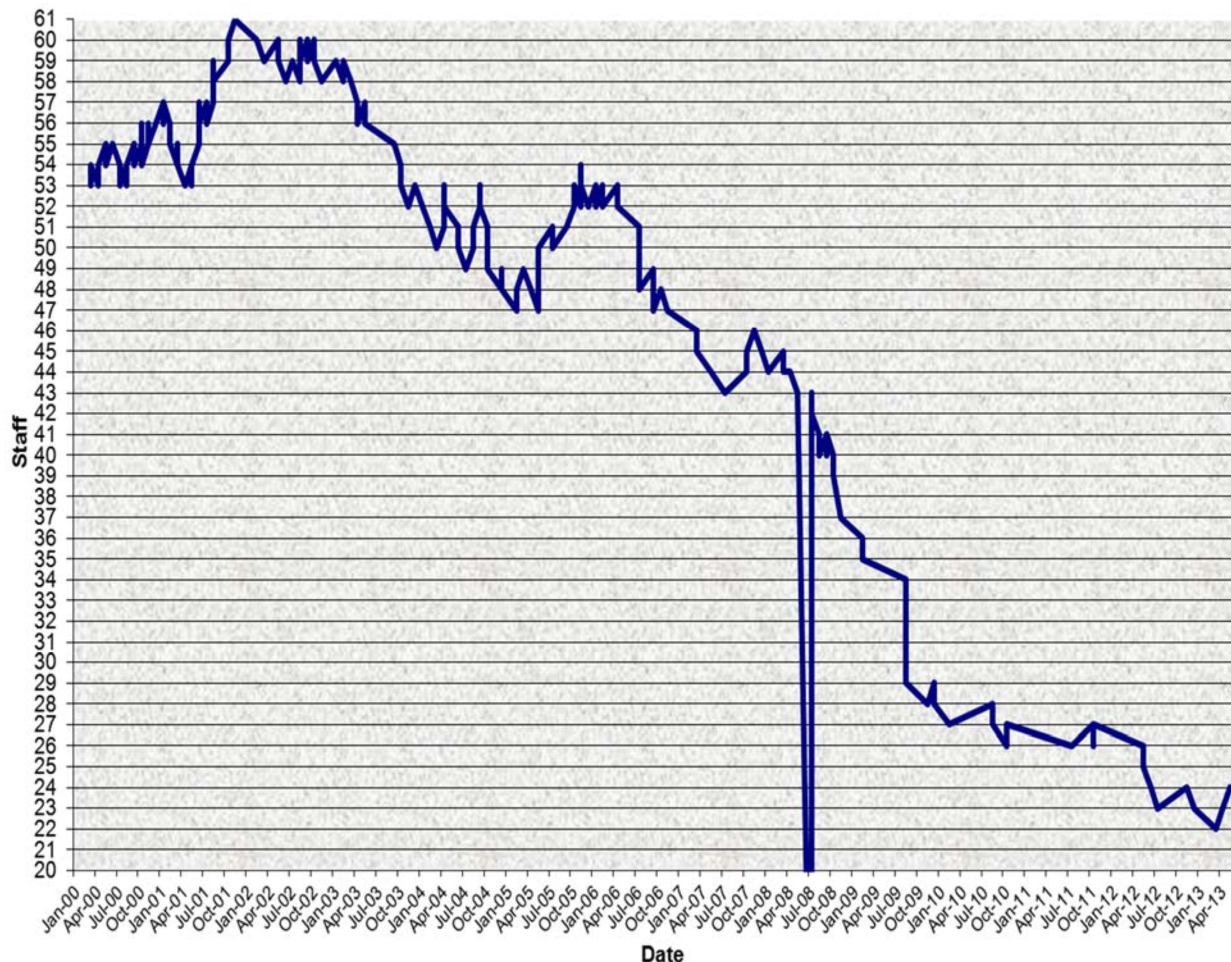
Finally, Act 3 extended the sunset date of the Council to June 30, 2014, and required the LB&FC to conduct an evaluation of the Council.

Complement Level

Exhibit 7 shows the number of filled positions reported by the Council since January 2000. The Council's organizational chart is shown in Exhibit 8.

Exhibit 7

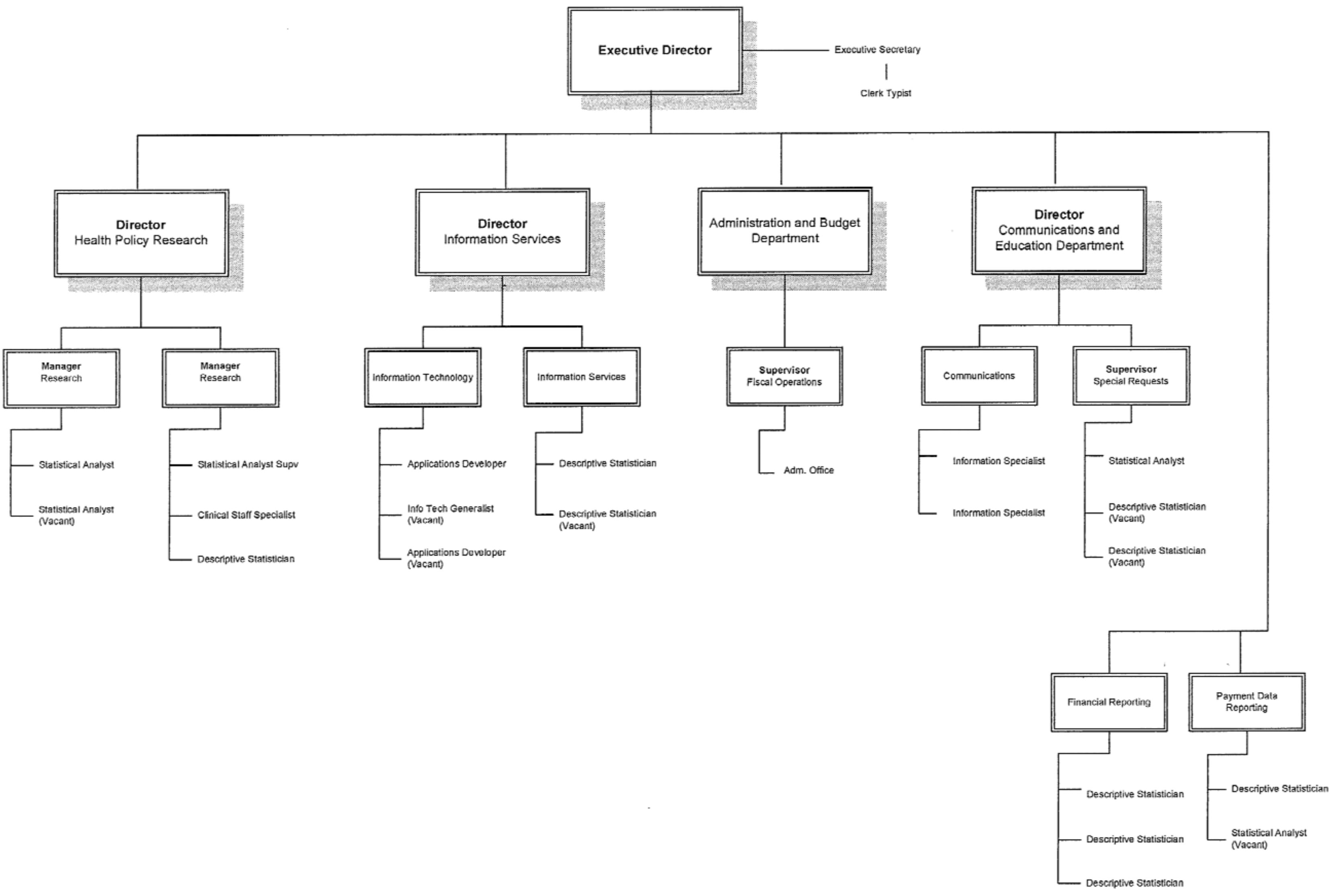
PHC4 Staff Size



Note: The up and down dip in 2008 reflects the 8 days PHC4 was without reauthorization in July 2008, when all staff were separated from service.

Source: PHC4.

Exhibit 8



Source: Pennsylvania Health Care Cost Containment Council.

Council Revenues and Expenditures

The Council received a General Fund appropriation of $2,683,000 for FY 2013-14, which is the same amount it received for FY 2012-13 and FY 2011-12.

Table 2 shows the Council's revenues from FY 2009-10 through FY 2011-12. Table 3 shows the Council's expenditures for this same time period.

Table 2

Pennsylvania Health Care Cost Containment Council Revenues

Revenues	FY 2011-12	FY 2010-11	FY 2009-10
General Fund	$2,683,000	$2,710,000	$2,844,000
Data Sales	647,865	751,042	586,305
Fiscal Code – Returned to General Fund	-	(450,625) 60%	(439,729) 75%
Total Revenues	$3,330,865	$3,010,417	$2,990,576

Source: PHC4.

Table 3

Pennsylvania Health Care Cost Containment Council Expenditures

Expenditures	FY 2011-12	FY 2010-11	FY 2009-10
Salaries/Benefits			
Salaries	$1,967,012	$1,907,553	$2,070,241
Benefits	602,879	515,446	449,530
Total Salaries/Benefits	$2,569,891	$2,422,999	$2,519,771
Operational Expenses			
Out Service Training	$ 200	-	-
Rent/Building	324,378	$ 362,140	$ 226,039
Advertising	3,771	5,072	19,030
Telephone	6,865	7,527	9,905
Printing	40	1,558	4,067
Postage	1,274	1,253	3,783
Office Supplies	334	2,479	2,827
Legal Expense	17,058	21,251	28,495
Equipment Maintenance & Rental	18,145	26,720	25,889
Computer Software and Supplies	23,985	25,038	91,191
Memberships/Subscriptions	24,266	30,924	22,330
Other	2,367	5,680	3,588
Total Operational Expense	$ 422,683	$ 489,642	$ 437,144
Council Expenses			
Travel	$ 3,119	$ 2,664	$ 3,205
Lodging	1,525	1,273	1,185
Meals	70	630	337
Meetings	-	-	52
Parking	418	237	571
Technical Advisory Group	-	-	1,318
Other	365	159	1,055
Total Council Expenses	$ 5,497	$ 4,963	$ 7,723
Staff Expenses			
Travel	$ 1,198	$ 505	$ 1,386
Lodging	274	136	
Meals	98	-	130
Meetings	18	-	-
Other	77	8	186
Total Staff Expenses	$ 1,665	$ 649	$ 1,702
Fixed Assets			
Telephones	$ 27	-	$ 916
Computer Equipment	48,279	$ 4,686	20,189
Total Fixed Assets	$ 48,306	$ 4,686	$ 21,105
Contracted Services			
Financial Auditing	$ 9,900	$ 11,400	-
Data Storage	1,953	1,868	$ 1,838
Software Lease	29,461	28,755	28,710
Miscellaneous Services	4,907	23,901	4,199
Total Contracted Services	$ 46,221	$ 65,924	$ 34,747
Total Expenditures	$3,094,263	$2,988,863	$3,022,192

Source: PHC4.

VII. Appendices

APPENDIX A

PHC4 Response to 2007 LB&FC Recommendations

Pennsylvania Health Care Cost Containment Council

RESPONSE TO 2007 LB&FC RECOMMENDATIONS

1. NATIONAL REPORTING METHODS – FULLY IMPLEMENTED

Specific to Recommendation 1, is the suggestion of LB&FC that the Council "initiate a major independent reassessment of its approach to patient severity adjustment..." The Council's most recent reauthorizing legislation called for a change in how the Council collects data used in its risk-adjustment methodology. According to Act 3 of 2009, the Council *shall not require any data sources to contract with any specific vendor for submission of any specific data elements to the council.* This provision was effective July 1, 2010.

After passage of Act 3, the council took steps to transition to an "in-house" approach to collecting patient laboratory data to be used in risk adjustment. In doing so, the Council was guided by its Technical Advisory Group, Data Systems Committee, Act 3 Review Committee, the scientific literature supporting the role of laboratory data in risk-adjustment, and feedback obtained from a public comment period. Beginning with Quarter 1, 2011 data, hospitals began submitting laboratory data directly to PHC4. As long as the data specifications are met, hospitals can use a method of their choosing to submit the data, including a free online tool that is available on PHC4's web portal.

In addition to the laboratory data, the council continues to collect *select* supplemental clinical data for risk adjustment of its surgeon-specific report on cardiac surgery. This data represents a subset of that previously collected via a third-party vendor. Like the laboratory data, this information is also collected in-house. Hospitals submit the data via a secure online tool. The decision to continue the collection of this data was based on the following:

- As recommended by the LB&FC, the Council considered whether data from the Society of Thoracic Surgeons (STS) National Cardiac Surgery Database could be obtained from the 60 hospitals in PA that performed cardiac surgery in 2010. Collecting the data from STS was also a recommendation received from several hospitals during the public comment period. The Council surveyed the relevant hospitals regarding their willingness to share the STS data. Of the 60 hospitals, 55 responded with 54 saying they collect STS data and one opting not to comment. Of the 54 that said they collect STS data, 42 said that they were willing to share the data with PHC4, 8 said that they were not willing to share the data, and 4 were undecided. These results were shared with the hospitals along with a second opportunity for hospitals to agree to share the data. No hospital changed its position.

  As an aside, the Council is currently working with STS and the PA children's hospitals on a proposed public report that would display cardiac surgery outcomes for pediatric patients. The children's hospitals approached the Council with the idea for such a report last year and have

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voluntarily agreed to use the STS data for the report. This project might serve as a template for working with STS on the adult cardiac surgery report in the future.

- Given that over 20 percent of the responding hospitals indicated that they would either not share the STS data or were unsure about sharing the data, the Council pursued the in-house collection of select clinical elements specific to cardiac surgery. In making the decision to move forward with this approach, the Council surveyed the hospitals with regard to the difficulty of collecting the data and was guided by recommendations of its Technical Advisory Group. The in-house collection of the supplemental clinical data began with Quarter 3, 2011 data.

- Like other state data organizations, the Council is encouraged that present on admission (POA) indicators are required as part of the national hospital discharge billing form. While the Council's data collection process edits these indicators to ensure that the responses are valid, a more thorough review to determine indicator accuracy is needed. Budget constraints and staff reductions have limited such activity. The Council's early testing of risk-adjustment models using POA indicators showed results that were inconsistent with previous models, raising caution. The accuracy of these indicators has been examined in the scientific literature with mixed results. Nonetheless, present on admission indicators could prove extremely valuable to future risk adjustment enhancements once acceptable levels of accuracy are obtained.

Finally, Recommendation 1 comments generally on the Council identifying ways to "coordinate and align its current data collection and reporting requirements with national reporting initiatives..." The Council enjoys a cooperative relationship with national entities focused on health care data collection and research and is often guided by their activities. For example, the Council used the Prevention Quality Indicators developed by the Agency for Healthcare Research and Quality (AHRQ) in a recent report on potentially preventable hospitalizations and often relies on AHRQ's Clinical Classifications Software when defining study populations. The decision to collect laboratory data for risk-adjustment purposes was guided, in part, by research findings sponsored by AHRQ. As a partner in AHRQ's Healthcare Cost and Utilization Project (HCUP), the council's data is utilized at the national level for a broad range of health research and health policy studies.

2. <u>RFP ON VENDOR COST – NOT APPLICABLE</u> – Changes to Act 3 of 2009 and subsequent action by the Council render this recommendation moot. Please see Recommendation 1, above.

3. <u>COMMITTEE MEETINGS – FULLY IMPLEMENTED</u> – All full Council meetings and all committees, including Advisory Groups, are held in open session. These meetings are publicized as required and minutes are kept.

4. <u>COMMONWEALTH MANAGEMENT DIRECTIVES – PARTLY IMPLEMENTED</u> - As an independent agency, the Council is not subject generally to management directives applicable to agencies under the Governor's jurisdiction. However, as noted by LB&FC, the Council has adopted certain provisions of Commonwealth Management Directives, paying particular attention to those that are relevant to the

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Council's operation and which align with the governing and fiduciary responsibilities of the Members of the Council.

As the Council's staffing complement in the Administration and Budget Unit dropped from seven to two FTEs since 2007, the Council has correspondingly increased its use of the Office of Administration's services. The remaining activities are best carried out by onsite Council staff.

With regard to securing central legal services, the Council believes that its independent status is best served by a contractual arrangement with outside legal counsel. This contract is put out for public bid periodically. At the same time, the Council recognizes that the Office of General Counsel has knowledge and experience with particular issues relevant to its operation as a state entity and has used and benefited from their services (e.g., "Right to Know" requests).

5. CODE OF CONDUCT – PARTIALLY IMPLEMENTED - In September 2008, the Governor's Code of Conduct was adopted internally for PHC4 staff. Annual Statements of Financial Interest are completed by appropriate PHC4 staff, in accordance with the requirements established by the PA State Ethics Commission.

The Council opted not to adopt the Governor's Code of Conduct for Members, as it relates to those who are compensated by the Commonwealth of PA. Instead, the Council adopted a Conflict of Interest Policy on February 19, 2009. Council Members also continue to comply, as they always have, with the filing of annual Statements of Financial Interest with the Pennsylvania State Ethics Commission.

6. NEW MEMBER ORIENTATION – FULLY IMPLEMENTED - Council has developed a new member orientation packet and holds an orientation session with each new member as they assume their duties.

7. AUDITOR GENERAL – NOT IMPLEMENTED – The Council has opted to continue its practice of contracting with an independent financial firm to conduct its annual audit. The firm is hired through the appropriate public bidding process. The firm which has conducted the Council audits for the past five years has extensive experience in governmental finances.

8. INTERNAL AUDIT – NOT APPLICABLE –In October 2007, the Council issued an RFP for consultative/performance review services. No proposals were submitted and the Council opted to not pursue this activity.

9: PAYOR ADVISORY GROUP – FULLY IMPLEMENTED - The Council had maintained a payor advisory group, ad-hoc, prior to the previous LB&FC audit. In 2009, the General Assembly formalized this committee with new reauthorizing language, and it has met periodically since that time.

10: RELEASE OF DATA – FULLY IMPLEMENTED - The Council has not released non-disclosable data since receiving the LB&FC 2007 report. The Council disagrees that new regulations are needed to release "protected" data since these data, under current regulation, MAY (not shall or shall not) be released under terms and conditions established by the Council. The Council has authority to do so under its current statute and regulations and has done so. We do not disagree that clarification in the statute

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might be helpful and note that an opportunity to do so will present itself when the enabling statute is up for reauthorization. Finally, LB&FC recommended that more information be provided with regard to the annual report published in the PA Bulletin, listing the data purchasers for the previous year. The Council now provides a more detailed description of the data requested, along with the name and entity making the request.

11. ATLAS DATA – FULLY IMPLEMENTED – The Council no longer requires hospitals to utilize MediQual or any other single vendor to submit data to PHC4. And the Council has not released key clinical findings from the previously collected Atlas data since receiving the 2007 LB&FC report.

12. CONSUMER SEAT – FULLY IMPLEMENTED – There is currently a consumer representative serving on the Council.

13: BUDGET REVENUES – FULLY IMPLEMENTED – The Council has received approval to use revenue earned from the sale of data for its general operations for the past three fiscal years through express language contained in the Fiscal Code.

14: MANAGED CARE REPRESENTATIVE – FULLY IMPLEMENTED – This language was deleted from the statute in June of 2009.

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APPENDIX B

NOTICES
HEALTH CARE COST CONTAINMENT COUNCIL
Special Reports and Requests for Data
[43 Pa.B. 1382]
[Saturday, March 9, 2013]

The Health Care Cost Containment Council (Council), according to Act 89 as amended by Act 14 and as amended by Act 3, is required to publish a list of all special reports and data that have been prepared during the previous calendar year. The following represents a summary of the reports and requests for data generated by the Council in calendar year 2012. The list of data fields that are included in the standard public use files are located in PDF files posted on the Council's web site www.phc4.org under ''Services and Data Descriptions.'' Questions about procedures for obtaining access to Council data should be addressed to JoAnne Z. Nelson, Supervisor, Special Requests Unit, Health Care Cost Containment Council, 225 Market Street, Suite 400, Harrisburg, PA 17101, (717) 232-6787, jnelson@phc4.org.

Applicant and Project Description

Agency for Healthcare Research & Quality—Jenny Schnaier

Statewide 2011 inpatient discharge and inpatient revenue code detail datasets to be used in the Healthcare Cost and Utilization Project (HCUP), which uses the data for multiple databases, reports, and tools and products. The HCUP databases enable research on a broad range of health policy issues, including cost and quality of health services, medical practice patterns, access to health care programs and outcomes of treatments at the National, regional, State and local levels.

Altoona Regional Health System—Jerry Murray

A custom 2008 through 2010 inpatient discharge and ambulatory/outpatient procedure dataset for specified zip codes to produce market share analysis that will assist in the development of a 3-year strategic plan targeted to better serve patients in the area and to determine the services required.

A custom 2010 inpatient discharge dataset of patients residing in 29 specified counties to be used to perform a patient analysis.

A custom 2011 inpatient discharge and ambulatory/outpatient procedure dataset of cases for specified zip codes that will be used for internal market share analysis.

AtlantiCare Regional Medical Center—Rosemary Nuzzo

A standard regional 2011 inpatient discharge dataset for Regions 8 and 9. O'Conco Healthcare Consultants will analyze the data on behalf of AtlantiCare Regional Medical Center. The data will be used for various web-based health statistic reports, as a reporting tool focused on the epidemiology of health services to estimate demand for health services, and to measure morbidity and comorbities that will be used by AtlantiCare in comparing to peer hospitals.

Blue Cross of Northeastern Pennsylvania—Kevin Brennan

Standard Statewide 2010 through 2011 inpatient discharge and inpatient revenue code detail datasets to be used to analyze data for network accessibility.

Bon Secours Health System, Inc.—Akbar Khan

A 2011 inpatient discharge and ambulatory/outpatient procedure standard Region 6 dataset and a custom dataset of records of patients who reside within Region 6. The data will be used to help determine the variations in health status and access to care and to develop appropriate programs and services over time. In addition, the data will be used to assess community need by geographic area, type of diagnosis, mode of access and other variables, compared to National and local benchmarks to help quantify the needy and underserved segments.

Appendix B (Continued)

Boston University School of Medicine—Amresh Hanchate

A modification to previous requests for a custom fourth quarter 2003 through third quarter 2010 inpatient discharge dataset with readmission indicator and the Federal fiscal year of adult cases with a congestive heart failure or pneumonia condition and 30-day readmission information (Q3 2003-Q4 2010). The data will be used for The Effects of Massachusetts Health Reform on Access to Care and Disparities study that is to evaluate whether the expansion of major health insurance coverage in Massachusetts has improved access to care and reduced disparities in care.

Chart Institute—Colleen Vrbin

A standard facility 2011 inpatient discharge dataset for 40 hospitals: ACMH, Bradford Regional, Butler Memorial, Chambersburg, Charles Cole Memorial, Clarion, Clearfield, Corry Memorial, Elk Regional, Ellwood City, Evangelical Community, Fulton County, Good Samaritan/Lebanon, Grove City, Hazleton General, Highlands, Indian Regional, J C Blair Memorial, Jameson Memorial, Jersey Shore, Latrobe Area, Lewistown, Lock Haven, Meadville, Memorial/Towanda, Monongahela Valley, Moses Taylor, Mount Nittany, Nason, Punxsutawny Area, Robert Packer, Saint Catherine, Sharon Regional, Soldiers and Sailors, Somerset, Titusville Area, Uniontown, Warren General, Wayne Memorial and Waynesboro. Chart Institute is planning to use the data to identify potential areas to target quality improvement initiatives at the Pennsylvania hospitals of Chart RRG, as well as several other community hospitals that may be future members and others to use for comparison.

Children's Hospital of Philadelphia—Scott Lorch, MD

A custom inpatient discharge dataset with derived data fields (number of days between admissions and number of days to death) of mother delivery records and newborn birth records (1995-Q1 2010), with moms' and newborns' readmission records (1995-Q3 2010), linked with Department of Health newborns' birth certificate data (1995-2009) and mothers' and newborns' death data (1995-2010) records based on a cohort of infants born or a fetal death (stillbirth) during 1995 through 2009. The data will be used for an "Impact of Obstetric Unit Closures on Pregnancy Outcomes" study. The goal of the study is to maintain or improve the value and efficiency of obstetric care as the supply of obstetric units change in a given market. The study results will be published in journals, a policy-relevant Issue Brief distributed to policymakers and health professionals, and presented to the American College of Obstetrics and Gynecology, Pediatric Academic Societies and Academy Health.

Community Health Systems—Debbie Landers

Standard Statewide 2011 inpatient discharge and ambulatory/outpatient procedure datasets to be used to create utilization rates and market share information to be used in strategic and facilities planning for the following 15 facilities: Berwick Hospital, Brandywine Hospital, Easton Hospital, Jennersville Regional Hospital, Pottstown Memorial Hospital, Lockhaven Hospital, Chestnut Hill Hospital, Phoenixville Hospital, Sunbury Community Hospital, Moses Taylor Hospital, Mid Valley Hospital, Special Care Hospital, Tyler Memorial Hospital, Wilkes-Barre General Hospital and Regional Hospital of Scranton.

DataBay Resources—Steve Sekely

Standard Statewide second quarter 2011 through second quarter 2012 inpatient discharge and ambulatory/outpatient procedure datasets and 2011 through second quarter 2012 inpatient and ambulatory/outpatient revenue code detail datasets. The data will be combined with other all-payer health care data to be used to produce various aggregate report files that are offered as health care software products to DataBay's customers.

Ellwood City Hospital—Chris Little

A custom 2009 through first quarter 2012 inpatient discharge dataset of records of patients who reside in Allegheny, Armstrong, Beaver, Butler, Lawrence, Mercer or Venango Counties or in Ohio. The data will be used to prepare a strategic plan for the hospital.

Evangelical Community Hospital—Tami Radecke

Standard regional fourth quarter 2010 through third quarter 2011 inpatient discharge and ambulatory/outpatient procedure datasets for Region 4 to be used to create utilization rates and market share information.

Feldman & Pinto Attorneys at Law—Brad McDermott

A custom 2002 through 2010 inpatient discharge data report of the total number of unilateral hip replacements and bilateral hip replacements each year to be used to verify facts discovered in pending litigation.

Appendix B (Continued)

Georgetown University—Jean M. Mitchell, PhD

A standard Statewide 2004 through 2011 ambulatory/outpatient procedure dataset. The data will be used to evaluate costs and payment rates of ambulatory surgery centers (ASC). The client will estimate cost functions for ASCs using panel data spanning 2004 through 2012 for Pennsylvania, and use its estimates to compare production costs and Medicare reimbursements for the most commonly performed outpatient surgical procedures. The project will examine these timely and significant policy issues using financial cost and patient discharge data available for facilities located in Pennsylvania.

Global Lower Extremity Amputation Study Group—Ronald Renzi

A custom 2011 inpatient discharge dataset of records of patients who reside in Philadelphia, Bucks, Chester, Delaware, and Montgomery Counties and had amputations in 2011. The data will be used for research on the most effective prevention strategies and trends in lower extremity amputation in Southeastern Pennsylvania.

Good Shepherd Rehabilitation Hospital—John Grencer

A standard regional 2011 inpatient discharge dataset for Regions 1, 5, 6, 7, 8 and 9 to be used for internal analysis of hospital services.

Harvard Pilgrim Health Care Institute—Grace M. Lee, MD

Standard Statewide 2006 through 2010 inpatient discharge and inpatient revenue code detail datasets. The data will be used for a project funded by AHRQ and titled "Intended and Unintended Consequences of Nonpayment for Preventable Complications." Specifically, the aims of the study are to: 1) evaluate the impact of the Centers for Medicare and Medicaid Services (CMS) policy on Healthcare-Associated Infections (HAI) rates reported by Medicare (that is, "billing" rates); 2) evaluate the impact of CMS policy on HAI rates reported by the National Healthcare Safety Network (that is, "true" infection rates); 3) assess whether the CMS policy has the intended impact of reducing both "billing" and "true" infection rates in different types of hospitals (for example, urban vs. rural, for-profit vs. nonprofit, and the like); and 4) assess whether reduced reimbursement for HAIs as a result of the CMS policy disproportionally affects hospitals that care for a high proportion of minority or poor patients.

HCR ManorCare—Kenneth Kang

A standard Statewide first and second quarter 2011 inpatient discharge dataset. The data will be used to assess the needs of the residents in HCR ManorCare's skilled nursing facilities in Pennsylvania.

HealthSouth—Steve Adams

A standard Statewide 2010 and 2011 inpatient discharge dataset to be used to help determine market share and needs to better serve HealthSouth's population base.

Highmark—Joseph J. Reilly

A standard Statewide 2011 inpatient discharge dataset to be used to conduct an all-payer market analysis to complement Highmark's market analysis.

Home Nursing Agency—Rich Lobb

Standard regional second quarter 2010 through first quarter 2011 inpatient discharge datasets for Regions 1, 2, 3, 4 and 5. The data will be used to identify and analyze clinically underserved areas within this Commonwealth to support new or existing clinical service delivery.

Hospital & Healthsystem Association of Pennsylvania—Martin Ciccocioppo

A custom 2010 and 2011 inpatient discharge data report of hospital 30-day readmission rates on cases with chronic obstructive pulmonary disease and congestive heart failure conditions by hospital. The data will be used to provide the CMS with Pre-Hospital Engagement Network (PA-HEN) rates of readmissions. The PA-HEN staff is interested in knowing hospital-specific rates in order to ensure hospitals with the greatest needs are addressed through the PA-HEN project and to identify the best performers to learn what they are doing right.

Standard Statewide 2011 through second quarter 2012 inpatient discharge dataset and 2011 and restated 2010 financial data report. The data will be used to conduct ongoing monitoring of Statewide, regional and hospital-specific quality outcomes, primarily utilizing the AHRQ Quality Indicators. Hospital & Healthsystem Association of Pennsylvania (HAP) may from time to time release the aggregate results of its quality monitoring research. HAP also intends to host MONAHRQ for member-only use on its private website.

Appendix B (Continued)

Hospital Council of Western Pennsylvania—Carmela Breslin

A custom fourth quarter 2008 through third quarter 2011 inpatient discharge and ambulatory/outpatient discharge data report on the number of births by hospital in Forest, Clarion, Jefferson and Venango Counties. The data will be used for a member facility, Clarion Hospital, that will analyze the data to see if it is worth hiring new OBGYN physicians or if an OBGYN physician partnership with others hospitals within the Pennsylvania Mountain Healthcare Alliance would be the best strategy moving forward.

IMS Health—Ed Burleigh

Standard Statewide 2011 inpatient discharge and ambulatory/outpatient procedure datasets. IMS will use the data for the validation of its hospital sample and National projections from its hospital discharge data for 2001-2011. The data will be used as the "gold standard" to ensure reasonable projections to the National level. IMS has numerous studies with government agencies such as the Food and Drug Administration and Centers for Disease Control and Prevention. This State data allows IMS to come up with a sound universe count for various hospital-based diagnoses and procedures.

Ingenix Consulting/OptumInsight—Holli Boetcher

Standard Statewide 2010 inpatient discharge dataset to be used for two products, a consumer hospital quality reporting tool for health plans to provide to their members and reports for health care professionals. The reports for consumers will provide information on inpatient quality and efficiency to aid in decision making about where to seek care. The reports for health care professionals will be benchmarking tools that analyze inpatient charges, volumes, lengths of stay and other measures by facility.

J.C. Blair Memorial Hospital—Christine R. Gildea

A custom 2008 through 2011 inpatient discharge and ambulatory/outpatient procedure dataset of records of patients who originate from Huntingdon County. The hospital will use the data to provide insights on patterns of patient care such as patient demographics, diagnosis/services, admission point and discharge placement within the hospital's market area for the work effort that is associated with completing a Community Health Needs Assessment. The data will also assist in strategic planning efforts by identifying services that consistently attract patients to other hospitals.

Kutztown University of Pennsylvania—Robert C. Ziegenfus

A custom 1997 through 2010 inpatient discharge and ambulatory/outpatient procedure dataset of records for children with an asthma diagnosis. The data will be used to analyze the asthma hospitalization data to augment the statistical and cartographic analysis of asthma prevalence data by county currently underway. The data will be analyzed to determine the rate of asthma hospitalization (inpatient and outpatient) for all Pennsylvania counties and to: 1) determine temporal changes across the years; 2) determine the spatial changes that have occurred across counties; 3) determine if there are gender or racial distinctions, or both, across counties; and 4) determine the cost of the asthma burden.

Lancaster General Health—Michael C. Boblitz

Standard Statewide second quarter 2011 through first quarter 2012 ambulatory/outpatient procedure datasets. The data will be used to understand demand and utilization for ambulatory surgery in Pennsylvania.

Lehigh University—Shin-Yi Chou

A standard Statewide 1990 through 2011 inpatient discharge dataset. The data will be used for research using advanced econometrics methods to address relevant health policy questions. The goal is to examine the access, quality and cost of health care in Pennsylvania to achieve fair, effective and efficient health care delivery as major health care reforms are undertaken. Specific aims are to explore the effects of hospital market structure, technology and health policies on access, quality and costs.

Lehigh Valley Health Network—Stephen L. Christopoulos

A standard Statewide second quarter 2011 and first quarter 2012 inpatient discharge dataset to be used for service area analysis, product line trends and analysis, competitive analysis, and incident rate comparison and trends for program development.

Appendix B (Continued)

Maryland Department of Health and Mental Hygiene—Cheryl De Pinto

A custom 2010 inpatient discharge dataset of records of Maryland residents hospitalized in Pennsylvania. The data will be combined with Maryland Health Services Cost Review Commission hospitalization data to derive rates of diagnoses and treatment for acute and chronic conditions including asthma, injury, births, heart disease and diabetes. Data will be aggregated and reported by demographics, diagnosis and procedure.

Meadville Medical Center—Denise A. Johnson, MD

A custom 2009 through third quarter 2011 inpatient discharge and ambulatory/outpatient procedure regional data report on the volume trends of in hospital coronary interventions performed to be used to evaluate the interventional cardiology program and project future needs.

Memorial Medical Center—Carrie Arcurio

Standard Statewide second quarter 2011 through first quarter 2012 inpatient discharge datasets to be used to internally evaluate Memorial Medical Center's and its competitors' performance and future opportunities. The data will be used to illustrate current market share and enhance various other planning tools such as budgets and 5-year plans.

Mid-Atlantic Health Care—Michael Mahon

A standard regional 2011 inpatient discharge dataset for Regions 8 and 9. The data will be used to assess the utilization of nursing homes in the market and discover if there are unmet care needs for seniors.

O'Conco Healthcare Consultants—Paul L. Chiafullo

A custom 2010 inpatient discharge dataset of all patient records for New Jersey residents to be used to develop summary reports for its clients including utilization rates, market share and benchmark comparisons of clinical, cost and revenue information. The data will also be included in a web-based report generation tool, "Primary Analysis," which allows clients to create reports using nonconfidential data.

Penn State College of Medicine—Kristen Kjerulff

A modification to a previous data request for additional custom data: first and second quarter 2011 inpatient discharge dataset of mother and newborn hospital records linked with the Department of Health birth certificate data of participants enrolled in "The First Baby Study" who delivered during 2011. The primary purpose of the study is to investigate the effects of mode of first delivery (vaginal vs. cesarean) on subsequent childbearing over a 5-year period.

Penn State College of Medicine—Robert Gabbay, MD, PhD

This request is for a custom second quarter 2010 through fourth quarter 2010 inpatient discharge and ambulatory/outpatient dataset of records based on a cohort file of the study population to be used for research purposes to analyze cost effectiveness of intervention in patients with diabetes.

Pennsylvania Department of Health—Carol Thornton, MPA

A custom 2011 inpatient discharge dataset of Statewide records to be used to prepare injury reports: 1) Injuries in Pennsylvania, Hospital Discharge—annual age-specific report of injury data by mechanism; 2) Injuries in Pennsylvania County Profiles—annual report containing State, regional and county data; 3) Injury-Specific Monographs—provides data on specific injury topics; and 4) Injury-Specific Fact Sheets—contain data on specific injuries, identifying risk factor and high-risk groups.

Pennsylvania Department of Health—James N. Logue, Dr. PH, MPH

A custom 2000 through 2011 inpatient discharge data report of acute myocardial infarction, asthma, carbon monoxide poisoning and heat stress related cases with ethnicity indicators by age group, county, gender and race to be used in the National Environmental Public Health Tracking Network. The data will be provided to the CDC to be used with other health outcomes data, exposure and bio-monitoring data, and environmental hazards and environmental monitoring data to be displayed in aggregate form on the CDC's public portal. Data will be analyzed to provide valid scientific information on environmental exposure and adverse risk of health conditions.

Pennsylvania Department of Health—Marina O. Matthew

A custom 2010 inpatient discharge data report of heart failure, nonfatal traumatic brain injuries, nonfatal spinal cord injuries, hip fractures, asthma or obstetric cases by age and race for each year. The data will be used as a part of a series of the Department of Health web pages containing state and local data that correspond to the Healthy People 2020 topics/objectives, as developed by the CDC.

Appendix B (Continued)

Pennsylvania Department of Health—Vadim Drobin

A custom 2011 inpatient discharge and ambulatory/outpatient procedure dataset of records of patients with a primary diagnosis of asthma. The Department of Health's Asthma Control Program will use the data to analyze morbidity for asthma risk education and prevention programs. The Asthma Control Program will provide the public and Pennsylvania Asthma Partnership, including healthcare providers, with asthma hospitalization data through press releases, conferences, presentations, asthma burden reports, focus reports and asthma fact sheets.

Pennsylvania Department of Health—Zhen-qiang Ma

A custom 2000 through 2011 inpatient discharge and ambulatory/outpatient procedure Statewide dataset with derived data fields (number of days between admissions and number of days to death) and 365-day readmission indicators, linked with Department of Health 2000 through 2010 death data and cancer registry data. The data will be used for the Chronic Disease Burden report, infectious disease hospitalization report and associated risk factor analysis.

Pennsylvania Department of Public Welfare—Jolene H. Calla, Esq.

A custom 2009 through 2011 financial data report of net patient revenue by hospital to be used for the Statewide hospital quality of care assessment program and the hospital assessment program for certain hospitals in Philadelphia County.

A custom third quarter 2009 through second quarter 2010 inpatient discharge dataset of verified self-pay records and 2008 through 2010 financial data report of a 3-year average percent of uncompensated care. The data will be used to compute payments to hospitals for the Hospital Uncompensated Care and Extraordinary Expense programs established under the Tobacco Settlement Act of 2001.

A custom third quarter 2009 through second quarter 2010 inpatient discharge dataset of records with an MDC 14 or 15 from general acute care hospitals. The data will be used to calculate payments to hospitals for obstetrical and neonate services.

Pennsylvania Department of the Auditor General—Jo Anne Walchak

A custom third quarter 2009 through second quarter 2010 inpatient discharge dataset of verified self-pay records and 2008 through 2010 financial data report of a 3-year average percent of uncompensated care. The data will be used to audit hospitals that received tobacco funds in 2012 from the Department of Public Welfare, which used Council data as part of their formula to compute payments to hospitals for the Uncompensated Care and Extraordinary Expense Programs established under the Tobacco Settlement Act of 2001.

Pennsylvania Office of Attorney General—Tracy W. Wertz

Standard Statewide 2005 through 2007 ambulatory/outpatient procedure and outpatient revenue code detail datasets and second quarter 2011 through fourth quarter 2011 inpatient discharge, ambulatory/outpatient procedure, inpatient revenue and ambulatory/outpatient revenue code detail datasets, and 2011 financial data report. The Office of Attorney General will use this data in its review of hospital mergers to ensure compliance with antitrust laws. The data will also be used by the Federal Trade Commission for hospital merger investigations that are conducted jointly with the Office of Attorney General.

Pennsylvania Patient Safety Authority—John Clarke

A custom third quarter 2004 through second quarter 2011 inpatient discharge and ambulatory/outpatient procedure data report on the number of surgeries performed in the operating room by facility. This information will be used to normalize data related to wrong site and wrong side surgeries performed in Pennsylvania.

A custom second quarter 2011 inpatient discharge and ambulatory/outpatient procedure data report of cases with ureteral stent procedures by facility. The data will be used to normalize data related to the number of reported adverse events associated with ureteral stent procedures in Pennsylvania.

Pennsylvania Patient Safety Authority—William Marella

A custom 2005 through 2011 financial data report of net patient revenue by year to be used to calculate adjusted patient days, a metric based on a combination of patient days and inpatient/outpatient revenues, which will be used for calculating fall rates.

Appendix B (Continued)

Philadelphia Department of Public Health—Giridhar Mallya

Standard regional 2010 inpatient discharge and ambulatory/outpatient procedure datasets for Regions 8 and 9. The data will be used for estimation of the geographic distribution, temporal trends, rates and costs of hospitalization for specific conditions (diabetes, asthma, and the like). Other areas to be examined include: diabetes complications, disparities in hospital outcomes, violence-related injuries, trends in HIV/AIDS inpatient/outpatient utilization, high-risk pregnancies, obstetrical service issues, infectious diseases, influenza and pelvic inflammatory disease.

Pittsburgh Regional Health Care Initiative—Colleen Vrbin

A custom 2007 through 2010 inpatient discharge dataset with derived data fields (number of days between admissions, episodes and charge per day) and indicators (diagnoses, complications and infections) of cases with an in-hospital death or discharge to hospice during 2010 with their preceding hospitalization records since 2007. The data will be used to understand hospitalization patterns for patients at the end of life in an effort to improve healthcare safety and quality.

A custom fourth quarter 2008 through first quarter 2011 inpatient discharge dataset with derived data fields (number of days between admissions, episodes and charge per day) and indicators (diagnoses, complications and infections) of hospitalizations in Region 1 or Lawrence, Somerset and Indiana Counties. The data will be used to study hospital readmission rates for chronic diseases in an effort to improve health care safety and quality, and to help plan initiatives for improving health care in the Southwestern Pennsylvania region.

Press Ganey Associates, Inc.—Jim Strunk

A standard Statewide 2010 inpatient discharge dataset. The data will be used in health care benchmarking reporting packages and studies. Additionally, information from Medicare Cost reports, internally created RAMI and RACI processes, AHRQ indicators, geo-spatial information and various other sources will be used in conjunction with this data to develop hospital-based metrics for clinical, operating and financial metrics. Only aggregate information will be displayed.

Service Employees International Union—Robb Streicher

A standard Statewide 2010 inpatient discharge and ambulatory/outpatient dataset. The data will be used to assess the delivery of services in terms of access, cost and quality of care and impact of delivery of services in multiple settings. The Service Employees International Union wants to understand the sources of variation in these aspects of health care provisions to ensure beneficiaries receive the right care, at the right time, in the right setting and to reduce unwanted variations in health care delivery that ultimately lead to cost savings through the elimination of under-use of effective care and over-utilization of supply-sensitive care.

SG-2, LLC—Tracy Pfeiffer and Jeffrey B. Ridge

Standard Statewide 2011 through first quarter 2012 inpatient discharge datasets. The data will be used to support client hospitals' short and long-term operational and strategic planning efforts. The data will be calculated into market share reports by clinical area and geography. Products developed from the data reflect summary level analytics to provide clients with the ability to project and meet future demands by determining appropriate allocation of resources and improve the quality of health care within their communities.

Surgical Specialty Center of Northeastern Pennsylvania—Julie Bingham

A custom 2011 ambulatory/outpatient procedure data report of the number of YAG laser procedures and all procedures performed at freestanding ASCs by facility and payer to be used internally as an analytical tool.

Susquehanna Health—Susan Browning

Standard Statewide 2008 through 2010 inpatient discharge dataset to be analyzed by Healthy Communities Institute to produce a web based platform report focused on asthma, alcohol abuse, congestive heart failure, COPD, dehydration, diabetes, hepatitis, urinary tract infection and pneumonia cases. The reported analysis will be used by Susquehanna Health, Jersey Shore Hospital and Laurel Health System as part of their Community Health Needs Assessment, which is a Patient Protection and Affordable Care Act (PPACA) mandate for non-profit hospitals. As part of the PPACA, the data results will be reported in aggregate form on all three hospitals' websites. The information will help determine which populations need help and/or the diseases that the facilities treated at a higher rate than the State or National average.

Appendix B (Continued)

Susquehanna Health—Teia Engel

Standard regional third quarter 2010 through third quarter 2011 inpatient discharge dataset for Regions 4 and 6. The data will be loaded into Susquehanna Health's Customer Relationship Management database, which primarily will use this information to report market share and trend information for Susquehanna Health.

Temple University Health System—Christopher Snyder

Standard Statewide 2010 inpatient revenue code detail dataset. The data will be used, in part, for Temple University Health System's application to the CMS bundled payment initiative. The analysis of the data will be performed by Applied Medical Software for Temple University Health System's Performance Based Incentive System. The data will be combined with patient-specific data for assigning APR DRGs and calculating costs by using Medicare's ratio of costs to charges. The data will be aggregated by APR DRG to establish a norm that will be compared to actual cost.

Temple University Pulmonary & Critical Care—Jerry Criner, MD

A modification for additional calculations to a previous custom request of 1990 through 2009 inpatient discharge dataset of COPD cases and 1-year readmission records with derived data fields (number of days between admissions and number of days to death) and indicator fields (respiratory, critical care unit, and intensive care unit) linked with the Department of Health 1990 through 2009 mortality data. The data will be used to study: 1) the epidemiological changes in acute COPD exacerbations over the last 20 years in Pennsylvania and the cost of inpatient COPD treatment in the State; and 2) how readmission rate and all-cause and COPD-specific mortality is affected by: rural vs. urban location, impact of gender and age, zip codes as surrogates of air quality and socioeconomic status, all-cause and COPD-specific mortality, readmission rates, hospitalization duration and academic teaching vs. community hospital.

Thomas Jefferson University—Albert G. Crawford, PhD

Standard regional 2004 through second quarter 2011 inpatient discharge dataset for Regions 8 and 9. The data will be used for research on: 1) the degree to which recent, post-legislation decreases in AMI hospitalization rates are associated with, and possibly attributable to, workplace smoking ban legislation; and 2) whether recent reductions in AMI hospitalization rates have been accompanied by similar reductions in hospitalization for other chronic conditions (coronary artery disease, congestive heart failure, asthma and COPD) caused or exacerbated, or both, by smoking and second-hand smoke exposure. The findings will be submitted for publication in a peer-reviewed journal and a similar final report will be provided to the Philadelphia Department of Public Health.

Treo Solutions—Horen Boyagian

Standard Statewide 2010 inpatient discharge and inpatient revenue code detail datasets. The data will be used by Treo Solutions to conduct analysis for existing and new clients including providers, payers and State agencies. The data can serve as a foundation for quality improvement efforts and build upon other published information which detail financial or clinical performance. The data will be grouped into weight adjusted categories and assigned APR-DRG. The assigned categories and associated volumes will be used to analyze market share, hospital clinical cost and performance for clients in Pennsylvania and surrounding areas.

Truven Health Analytics—Katherine Blumhardt

Standard Statewide second quarter 2011 through second quarter 2012 inpatient discharge and ambulatory/outpatient procedure datasets to be used to be processed, standardized and distributed to their clients through decision tools, benchmark databases, research, custom studies and other associated products.

United States Department of Commerce Bureau of Economic Analysis—Abe Dunn

A standard Statewide 2002 through 2008 inpatient discharge dataset and regional 2004 through 2008 ambulatory/outpatient procedure dataset for Regions 1, 2 and 3. The client will use the data to study the value of health care networks and measure the economic impact of contracting with local hospitals on the cost of entering the local health insurance market. This study will help in understanding the drivers in the growth of health care costs and measure health care quality. The study will be shared through academic publications, working paper series and academic conferences.

Appendix B (Continued)

United States Environmental Protection Agency—Zachary Parker

Standard Statewide 2008 through 2010 inpatient discharge dataset to be used to calculate incidence rates so that the United States Environmental Protection Agency can conduct research of risk assessment on the health impact of air pollution.

University of Pennsylvania—Amy Tsou

A custom 1999 through 2009 inpatient discharge dataset with derived data fields (number of days between admissions) and indicators (index, transfer and diagnoses) of cardiac arrest and/or acute myocardial infarction cases to be used to investigate the incidence and outcomes of inter-facility transfers for myoclonic epilepsy after cardiac arrest.

University of Pennsylvania—Shreya Kangovi

A custom second quarter 2011 through fourth quarter 2011 inpatient discharge dataset of patients enrolled in the Patient-Centered Transition (PaCT) project with 90-day readmission records through first quarter 2012 with derived data fields (number of days between admissions) and index indicator. The data will be used to evaluate the program that is designed to help uninsured and Medicaid patients with the challenges of being discharged from a hospital. The PaCT Project is a randomized controlled trial of an intervention in which community health workers provide social support, advocacy, and navigation to low-income patients during the transition from hospital to primary care.

University of Pennsylvania Medical Center—Patrick F. Fogarty, MD

A standard Statewide 2007 through 2011 inpatient discharge dataset to be used for research purposes. The data will be analyzed by looking at different comorbidities among persons with congenital bleeding disorders. Insights from the analysis will assist clinicians in counseling their patients with congenital disorders of hemostasis, provide a basis for prospective studies and advance preventive health care efforts.

University of Pennsylvania School of Nursing—Rachel Kelz

Standard Statewide 2005 through 2011 inpatient discharge dataset. The data will be used to: 1) evaluate outcomes for women undergoing lower extremity bypass (LEB) surgery for peripheral vascular disease (PVD) when compared to male patients; and 2) identify hospital characteristics associated with optimal patient outcomes for women undergoing LEB for PVD. The findings from this analysis may result in publications, collaborations and grant proposals to address gender-relevant interventions that show promise to improve the delivery of surgical care for women.

University of Pittsburgh—Allan Tsung, MD

A custom 2006 through 2011 inpatient discharge dataset with derived data fields (number of days to events of services) of patients diagnosed with specified diagnoses, linked with 2006 through 2011 Department of Health's cancer registry data. The data will be used to complete an NIH-funded and University of Pittsburgh IRB-approved research study "Rates of Surgical Intervention for Intrahepatic Cancers Based on Distance to High Volume Center." The study will investigate the rates of surgical intervention for inpatients with intrahepatic cancers seen in Pennsylvania hospitals based on the distance between their homes and the hospital.

University of Pittsburgh Medical Center—Mathew Michaels

A standard Statewide second quarter 2011 through second quarter 2012 inpatient discharge and ambulatory/outpatient procedure dataset to be used to produce various research reports including: patient origin for UPMC hospitals, UPMC market share in various geographies and for various service lines, utilization trends in volume and market share over different time periods, and physician volumes at UPMC and other hospitals.

University of Pittsburgh School of Medicine—Margaret Ragni

A custom 2007 through 2011 inpatient discharge dataset of pregnancy-related records with derived data fields (number of days between admissions and death) and disease indicators linked with 2007-2011 Department of Health mortality and birth certificate data. The data will be used to estimate the incidence and prevalence of postpartum hemorrhage among deliveries in women with and without Von Willebrand disease, other bleeding disorders and sickle cell disease. Deliveries will be compared by demographics, comorbidities, medical conditions, pregnancy complications, pregnancy outcomes, hemostatic agents, uterotonic agents, severity of illness (if available), length of stay and mortality. The incidence, prevalence and risk factors for pulmonary embolism (PE) among sickle cell disease deliveries will be estimated. Admissions during pregnancy, during delivery and during the postpartum period will be determined for the various conditions.

Appendix B (Continued)

University of Pittsburgh School of Medicine—Steven L. Orebaugh, MD

A custom 2001 through second quarter 2011 ambulatory/outpatient procedure dataset of readmission data for patients who underwent ambulatory shoulder surgery at UPMC Mercy South Side Surgery Center and were readmitted within 5 days of surgery with the number of days between admission. The client is conducting a retrospective research study to evaluate and report the safety aspects of their anesthesia techniques for ambulatory shoulder surgeries.

University of Pittsburgh, Department of Medicine—Mark S. Roberts, MD, MPP

A modification to previous requests for a custom 2008 through first quarter 2011 inpatient discharge dataset of readmission records with number of days between admissions of patients who were diagnosed with a positive CT-scan for PE at a UPMC facility during 2008. The data will be used to evaluate the diagnostic performance of new CT-derived biomarkers of PE to assess whether they improve prediction of prognosis in acute PE. The data will be used to determine readmission rates and recurrent rates of thromboembolic disease for the cohort of patients with PE.

Wayne Memorial Hospital—Dave Hoff

Custom 2009 through first quarter 2011 inpatient discharge data reports of records of patients from specified zip codes by hospital and DRG to be used for market share analysis.

WellSpan Health—David Kimpel

A standard regional 2011 inpatient discharge and ambulatory/outpatient procedure dataset for Region 5. The data will be used for the internal assessment of the delivery of health care services within WellSpan Health's region. Service area utilization and analysis are the primary purposes for obtaining this data.

Widener University—Sandra Campbell

A custom 2010 inpatient discharge dataset of all patients with total hip arthroplasties and/or total knee arthroplasties procedures. The data will be used to continue a study on the impact of the Medicare 75% rule for patients with total joint arthroplasty, as part of a dissertation. An updated analysis will be performed on the discharge patterns after total joint arthroplasty to be shared in peer-reviewed forums, state or National conferences and publications.

Windber Medical Center—Cynthia L. Cassat

A custom third quarter 2008 through second quarter 2011 inpatient discharge data report of records of patients who reside in Somerset and Cambria Counties by DRG. The data will be used by Strategy Solutions, under contract with Windber Medical Center, to complete Windber's Comprehensive Community Needs Assessment which will identify the needs of residents living in Somerset and Cambria Counties.

JOE MARTIN,
Executive Director

[Pa.B. Doc. No. 13-428. Filed for public inspection March 8, 2013, 9:00 a.m.]

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APPENDIX C

Legislative Budget and Finance Committee
PO Box 8737
Harrisburg PA 17105-8737

Phone (717) 783-1600
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info@lbfc.legis.state.pa

Pennsylvania Health Care Cost Containment Council Member Questionnaire

23 Sent – 13 Returned – 57%

1. *The Pennsylvania General Assembly established the Council to promote health care cost containment through activities such as those listed below. How effective do you believe the Council has been in*:

a. Encouraging development of competitive health care services to contain health care costs and assure all citizens have reasonable access to quality health care?

3 (23%) - Highly Effective 5 (38%) - Effective 4 (31%) - Somewhat Effective
1 (8%) - Not Effective

b. Providing current, accurate health care data and information to purchasers and consumers and public officials on the quality and cost of health care delivered in inpatient and outpatient settings?

7 (54%) - Highly Effective 4 (31%) - Effective 2 (15%) - Somewhat Effective ___ Not Effective

c. Adopting a method to adjust data collected and disseminated by the Council to account for differences in patient illness levels.

9 (69%) - Highly Effective 3 (23%) - Effective ___ Somewhat Effective ___ Not Effective
1 (8%) - No Opinion

d. Making available patient and payer data and special reports in ways that meet statutory requirements to prevent the direct or indirect identification of an individual patient or payer, or disclose individual provider discounts?

8 (62%) - Highly Effective 5 (38%) - Effective ___ Somewhat Effective ___ Not Effective

e. Assuring the use of Council data does not raise barriers to care?

9 (69%) - Highly Effective 4 (31%) - Effective ___ Somewhat Effective ___ Not Effective

f. Making reports to the General Assembly?

9 (69%) - Highly Effective 2 (15%) – Effective 1 (8%) - Somewhat Effective ___ Not Effective
1 (8%) – No Opinion

g. Implementing outreach programs to make Council information understandable and usable to purchasers, providers, public agencies, and the general public?

4 (31%) - Highly Effective 5 (38%) - Effective 4 (31%) - Somewhat Effective ___ Not Effective

2. *Do you see opportunities for the Council to achieve its statutory objectives in a more cost efficient manner*? 1 (8%) - Yes 12 (92%) - No *If yes, please explain.*

Appendix C (Continued)

3. *Do you have any suggestions to improve the Council's management procedures and policies?* **2 (15%) – Yes 11 (85%) - No**
If yes, please explain. ______________________________

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4. *Do you have any suggestions to improve the availability and quality of the data the Council uses for completing reports?* **7 (54%) - Yes**
5 (38%) - No 1 (8%) – No Answer
If yes, please explain. ______________________________

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5. *In 2010, the Act 3 Review Committee recommended new or amended legislation be considered to empower the Council with expanded responsibilities and authority to address various issues raised in the Act 3 report, including reporting information beyond the inpatient and major ambulatory (outpatient) services setting and reporting additional payment data in the public domain. Please indicate whether you agree that the Council's authority should be expanded in these areas. We have also included space for you to provide information on other ideas you may have regarding how the PHC4's enabling legislation could be modernized.*

a. The Council's enabling legislation should be expanded to include reporting information beyond the inpatient and major ambulatory (outpatient) services setting.
11 (84%) - Agree 1 (8%) - Disagree 1 (8%) - No Opinion Please explain.

____

b. The Council's enabling legislation should be expanded to allow it to report additional payment data in the public domain. 10 (77%) - Agree __ Disagree 3 (23%) - No Opinion
Please explain.

____

c. Other "modernization" idea: ______________________________

____

d. Other "modernization" idea: ______________________________

____

e. Other "modernization" idea:

____

Appendix C (Continued)

6. ***Do you think the Council should be reauthorized?*** **13 (100%) - Yes ____ No** ***Please explain.***

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7. ***Do you believe the Council should undergo a sunset review?***
3 (23%) - Every 5 years ***5 (38%) - Every 10 years*** ***5 (38%) - Never (no specific sunset provision)*** ***Please explain.***

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8. ***Are there any other comments or suggestions you would like to make about the Council?***

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(Please attach additional sheets if necessary.)

Name: ______________________ Telephone: ________________ E-Mail: _________________

The identity of individuals responding to this questionnaire will remain confidential. Thank you for your assistance and cooperation with this study.

APPENDIX D

Legislative Budget and Finance Committee
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Pennsylvania Health Care Cost Containment Council
Questionnaire to TAG Members

---

9 Sent – 4 Returned – 44.4%

1. Please indicate your assessment of the methodologies the Council uses to complete reports in the following areas:

a. Cardiac Surgery: 4 (100%) - Excellent ___Good ___ Fair ____ Poor
If fair or poor, please explain:

____

____

____

b. Hospital Performance: 4 (100%) - Excellent ___ Good ___ Fair
If fair or poor, please explain:

____

____

____

2. Do you have any other concerns or suggestions about the availability or methodologies used to collect laboratory data in the Council's reports?

____

____

____

3. Would you like to make any other comments regarding the Council's operations, functions, or need for reauthorization?

____

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(Please attach additional sheets if necessary.)

Name: ______________________Telephone: _______________ E-Mail: ___________________

The identity of individuals responding to this questionnaire will remain confidential. Thank you for your assistance and cooperation with this study.

APPENDIX E

Legislative Budget and Finance Committee
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Pennsylvania Health Care Cost Containment Council
Questionnaire to PDAG Members

13 Sent – 4 Returned – 30.7%

1. Please indicate your assessment of the progress the group has made in terms of contributing to the Council's mission of reporting on health care payments and cost:
___ Excellent 2 (50%) - Good 2 (50%) - Fair ____ Poor
If fair or poor, please explain:

____

____

2. Please indicate your assessment of the appropriateness of the payment metrics and methodologies that the group has proposed for Council reports:
___ Excellent 3 (75%) - Good 1 (25%) - Fair ____ Poor
If fair or poor, please explain:

____

____

3. Do you have any other concerns or suggestions about PDAG's role in advising the Council on payment and cost issues?

____

____

4. Would you like to make any other comments regarding the Council's operations, functions, or need for reauthorization?

____

____

(Please attach additional sheets if necessary.)

Name: ______________________Telephone: _______________ E-Mail: ___________________

The identity of individuals responding to this questionnaire will remain confidential. Thank you for your assistance and cooperation with this study.

APPENDIX F

Legislative Budget and Finance Committee
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Pennsylvania Health Care Cost Containment Council
Questionnaire to Users of PHC4 Data

---

160 Sent – 29 Returned – 18%

1. How many data requests have you made to the Council over the past three years?

17 (59%) - 1–3
8 (27%) - 4–10
4 (14%) - More than 10

2. Overall, how would you characterize the quality of the PHC4 data you have received?

22 (76%) - Excellent   7 (24%) - Good   ___ Fair   ___ Poor

Comment: ____

____

3. Do you have any concerns over the quality of the PHC4 data you have received?

4 (14%) - Yes   25 (86%) - No   If yes, please explain. ____________________

____

4. How useful have you found the PHC4 data?

22 (76%) - Very Useful   5 (17%) - Useful   2 (7%) - Somewhat Useful ___ Not Useful

Comment: ____

____

5. Do you have any suggestions to improve the availability and quality of the data the Council uses for completing reports? 10 (34%) - Yes   15 (52%) - No
4 (14%) – No Answer

If yes, please explain.

____

____

Appendix F (Continued)

6. Health care has undergone major changes since the Council was created in 1986. Given these changes and the ongoing implementation of the Patient Protection and Affordable Care Act, are there any changes you believe the General Assembly should enact to "modernize" the Council's functions and responsibilities?

a. ____

____

b. ____

____

c. ____

____

7. Do you think the Council should be reauthorized? 27 (93%) Yes ____ No
2 (7%) – No Answer Please explain. ______________________________

____

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8. Are there any other comments or suggestions you would like to make about the Council?

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____

(Please attach additional sheets if necessary.)

Name: ______________________Telephone: ________________ E-Mail: _________________

The identity of individuals responding to this questionnaire will remain confidential. Thank you for your assistance and cooperation with this study.

APPENDIX G

Legislative Budget and Finance Committee
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Pennsylvania Health Care Cost Containment Questionnaire to Interested Parties

26 Sent - 8 Returned - 31%

1. ***How effective do you believe the Council has been in***:

a. Encouraging development of competitive health care services to contain health care costs?

__ Highly Effective 6 (75%) - Effective __ Somewhat Effective 2 (25%) - Not Effective

b. Providing current, accurate health care data and information to purchasers and consumers and public officials on the quality and cost of health care delivered in inpatient and outpatient settings?

2 (25%) - Highly Effective 4 (50%) - Effective 2 (25%) - Somewhat Effective __ Not Effective

c. Being "visible" to the health care community?

2 (25%) - Highly Effective 5 (63%) - Effective __ Somewhat Effective __ Not Effective
1 (13%) – No Answer

d. Being "visible" to the general public?

__ Highly Effective 1 (13%) - Effective 6 (75%) - Somewhat Effective __ Not Effective
1 (13%) – No Answer

Comments:

**2. *Do you see opportunities for the Council to achieve its statutory objectives in a more cost efficient manner*? 2 (25%) - Yes 3 (38%) - No
3 (38%) - No Answer
*If yes, please explain.***

**3. *Do you have any suggestions to improve the availability and quality of the data the Council uses for completing reports?* 5 (63%) - Yes 2 (25%) - No
1 (13%) No Answer *If yes, please explain.***

Appendix G (Continued)

4. ***The health care industry has undergone major changes since the Council was created in 1986. Given these changes and the ongoing implementation of the Patient Protection and Affordable Care Act, are there any changes you believe the General Assembly should enact to "modernize" the Council's functions and responsibilities?***

a. ____

____

b. ____

____

c. ____

____

5. ***Do you think the Council should be reauthorized?*** **6 (75%) - Yes**
1 (13%) - No **1 (13%) - No Answer**
Please explain.

____

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6. ***Are there any other comments or suggestions you would like to make about the Council?***

____

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(Please attach additional sheets if necessary.)

Name: ____________________Telephone: ______________ E-Mail: ______________

The identity of individuals responding to this questionnaire will remain confidential. Thank you for your assistance and cooperation with this study.

APPENDIX H

Response to This Report

Pennsylvania Health Care Cost Containment Council

September 19, 2013

Mr. Phillip R. Durgin
Executive Director
Legislative Budget and Finance Committee
400 Finance Building
613 North Street
Harrisburg PA 17105-8737

Dear Mr. Durgin:

Thank you for the opportunity to respond to the Legislative Budget and Finance Committee's Report entitled *Pennsylvania Health Care Cost Containment Council Performance Evaluation.*

I would like to express appreciation for the time invested in developing the report as well as the thoroughness and professionalism exhibited by your staff as reflected in the report.

The document is a thoughtful and accurate representation of how the Pennsylvania Health Care Cost Containment Council (PHC4) operates. In addition, your staff surveyed a large and diverse group of health care stakeholders – employers, labor groups, providers, insurers and academics - regarding their opinion as to the value PHC4 provides, and those responses were overwhelmingly positive.

Since 1986, PHC4 has been a valuable resource for the citizens of the Commonwealth - more than 700,000 of its reports were downloaded from its website over the past year. This resource will only increase in value as our health care delivery system continues to evolve rapidly and in dramatic fashion. Stakeholders must have good information to make good decisions.

The Legislative Budget and Finance Committee and its staff perform a valuable service and I thank you and your staff for your efforts. We look forward to a continuing discussion of the report.

Sincerely,

Joe Martin
Executive Director

225 Market Street, Suite 400, Harrisburg, PA 17101
Phone: 717-232-6787 • Fax: 717-232-3821 • www.phc4.org