Legislative Report on Outsourcing OHCS: Pros, Cons & Investigation of Federal Matching

April 27, 2020

Office of Health Care Statistics

PURPOSE

This report was produced in response to a written recommendation from the Legislative Fiscal Analyst, depicted below:

> *(1) We recommend that the Department of Health study the pros and cons of outsourcing the Office of Health Care Statistics including cost implications and report its findings to the Social Services Appropriations Subcommittee by May 1, 2020. (2) We recommend that the Department of Health investigate the possibility of receiving a higher federal match for some Health Care Statistics Program functions and report on its feasibility to the Social Services Appropriations Subcommittee by May 1, 2020.*

OFFICE OF HEALTH CARE STATISTICS OVERVIEW

The Office of Health Care Statistics (OHCS) implements the goals and directions of the Utah Health Data Committee (HDC). The HDC is created by §26-1-7 and membership and duties are outlined in the Health Data Authority Act (§26-33a). The HDC is composed of 15 members who have experience with health data and represent various perspectives from industry and community. These include public health, purchasers, providers, payers, and patients. The mission of the OHCS and the HDC is to support health improvement initiatives through the collection, analysis, and public release of health care information. These initiatives include increasing access to and quality of healthcare and reducing healthcare costs. The HDC ensures data are converted to objective baseline, trend, and performance measurement information, while preserving patient privacy and confidentiality.

The Office is responsible for maintaining, managing, and analyzing the following data series:

- **Consumer Assessment of Healthcare Providers and Systems (CAHPS)** – Annual customer satisfaction surveys relating to health plan performance.
- **Healthcare Effectiveness Data and Information Set (HEDIS)** – Annual quality measures relating to health plan performance.
- **Healthcare Facility Data** – Information about all inpatient, emergency room, and outpatient surgery and diagnostic procedures performed in the state.
- **All Payer Claims Data** – A data set which contains data about health care paid for by third parties. This includes insurers, plan administrators, dental and pharmacy benefit plans.

OUTSOURCING

CURRENT STATUS

The Office of Health Care Statistics currently expends approximately half its FY20 budget for outsourced/contracted functions. The current budget for OHCS is $1,776,500; $801,000 is currently for outsourced work.

The Office of Health Care Statistics consists of six full-time staff, and one part time staff. A large proportion of staffs' time is spent on data quality assurance, security, privacy and adhering to policy and compliance with statute. Many functions of the office have already been outsourced.

Functions currently outsourced and vendors used

- DataStat: Provides consumer satisfaction surveys (CAHPS) for health plan enrollees and medical home patients. The intent of these surveys is to provide objective, independent performance information to the Department and its programs about the consumer experience with commercial payers, government programs and other carriers.
- Mercer Health & Benefits, LLC/DTS UDOH: Transforms raw data files received from healthcare facilities into a quarterly and monthly data processing series of standardized, enhanced, and useful databases that reside on the Department's servers. This includes inpatient data, emergency department data and ambulatory surgery data.
- Milliman Solutions Inc.: Provides data management and data analytics on an ongoing basis with data suppliers (payers) using a secure on-line tool, quality assurance test, and ensuring compliance with reporting specification. Milliman is responsible for identifying and documenting requirements for systems, interfaces, and business process flows required to support and administer APCD data collection and processing.

Functions currently done by OHCS staff

- Carrying out legislative mandates for collection, processing and reporting of health data under Statute.
- Contracting with data processing and management vendors and overseeing the work.
- Serving as a neutral entity regarding medical cost and quality discussions.
- Making data available for use by approved requesters in a usable format.
- Working with payers and vendors to improve data quality and integrity of the data.
- Exploring data usage based on feedback from stakeholders.

- Participating in public health related research.
- Fulfilling statutory reporting in collaboration with the Utah Health Data Committee and its subcommittees, for example, planning reports to identify wasteful health care spending in the State (HB0195).
- Preparing various data products such as, clinic comparison reports, Healthcare Effectiveness Data and Information Set (HEDIS) reports, and Consumer Assessment of Healthcare Providers and Systems (CAHPS) reports.

Functions required to comply with Utah law

There are some functions that the Office of Health Care Statistics is required to do under Utah State Code. These functions cannot be outsourced unless there is a change in statute. These functions include, but are not limited to:

- Supervise and conduct the staff functions of the Utah Health Data Committee and assist the committee in meeting its responsibilities under chapter 33a (26-33a-105)
- Establish a plan for collecting data from data suppliers (26-33a-106.1 (1)(a))
- Share data with the Utah Insurance Department for risk adjustment and health insurers' premiums and rate filings (26-33a-106.1(1)(b))
- Assist the legislature and the public with awareness of, and promotion of transparency in the healthcare market (26-33a-106.1(1)(c))
- Provide enrollment data to the Utah Health Information Network for coordination of benefits (26-33a-106.1(1)(d))
- Coordinate with the State Emergency Medical Services Committee to publish data regarding air ambulance charges (26-33a-106.1(1)(e))
- Share data collected under this chapter with the state auditor for use in the health care price transparency tool described in Section 67-3-11 (26-33a-106.1(1)(e))
- Publish compilations or reports that compare and identify by name health care facilities, health care plans, and institutions based on quality standards, charges, and patient safety standards (26-33a-106.5(2) & (5))
- Report measures of cost and quality for routine and preventive care, and the treatment of diabetes, heart disease, and other illnesses or conditions and compare results for health care facilities or institutions, health care providers by geographic regions, and clinics' aggregate results (26-33a-106.5(6))

Other functions OHCS carries forth to satisfy statutory requirements includes:

- Compliance: Ensure compliance with statute and administrative rule across 42 payers (approximately 6,000 submissions per year) and 95 facilities (approximately 1,250 submissions per year)

- Records Maintenance: Establish and monitor OHCS policies and processes for classification, disposal and retention of records.
- Privacy and security: Authorize appropriate access to OHCS data products; conduct access reviews; determine correct fees; manage process for all data requests; attend RGE meetings at University of Utah.
- Administrative Rules: Manage seven administrative rules (R428); update rule as needed; ensure compliance to ERISA opt-in reporting.

OTHER STATES MODELS

In response to this request, the Office of Health Care Statistics reached out to the following states: Arkansas, Colorado, Kansas, Massachusetts, Maine, Minnesota, New Hampshire, Oregon, Rhode Island, Vermont and Washington. This outreach was done to ask about each state's current investment in their APCDs, and what functions, if any, were outsourced. The following is what was learned from that outreach:

- Arkansas budgets about $1.6MM to $1.8MM annually for its APCD, and no function is outsourced. The Arkansas Center for Health Improvement built, hosts, and maintains the Arkansas APCD in house. Since Arkansas does not receive full PII, it is unable to determine how many people are in its database.
- Delaware has 525,950 people in its database, which does not include Medicare Fee for Service data received from CMS. They were unable to share their annual budget, but indicated that start up expenses were $3MM over 2 years. Delaware's APCD is managed by its independent non-profit, the Delaware Health Information Network (DHIN). DHIN outsources to a technology vendor for hosting its AWS cloud, NTX platform and Amazon Redshift environments. DHIN is responsible for data validation and report writing.
- Washington's annual budget for its APCD is $5,113,992. The State holds administrative functions and outsources its database and website operations functions.
- In Colorado, CIVHC (Center for Improving Value in Health Care) manages all public and non-public data releases and is administrator of the database. Regulatory and oversight functions are held by the state. More details regarding the cost of Colorado's APCD is described in the next section of this report.

PROS OF OUTSOURCING

There are no clear advantages to outsourcing more than is currently being contracted. Several functions of OHCS would have to remain within the office as long as implementation and oversite are required by statute. These functions include contracting, contract oversite, fiscal oversite, compliance auditing and oversite. Functions that could potentially still be outsourced include data quality assessments, marketing, analysis and report drafts. Under our current funding structure it is unlikely we would be able to pay to outsource these and maintain the oversite responsibilities we would be mandated to do as outsourcing is typically more costly than doing these services in house.

CONS OF OUTSOURCING

Likely increase in APCD cost

A comparison between Utah and Colorado, who outsources administration of its APCD to the Center for Improving Value in Health Care (CIVHC) was conducted using the APCD Council website.

The conclusion was that Utah's total investment is less than that of Colorado's and there would be no notable savings to the State.

- CIVHC (Colorado) has an annual budget of $3.8 million, with an estimated 4.3 million persons in its database. This results in around $0.88 per person for Colorado's APCD.[1]
- Utah, by comparison, has an annual budget of $800,000 with an estimated 2.1 million persons in its database. This results in around $0.38 per person.[2]

Outsourcing the APCD to a vendor, like Colorado has, is likely to result in additional expenses for Utah. An external entity may require high startup costs. These would include higher overhead of employee salaries, benefits, and other expenditures (office space, utilities, etc.).

Possible barriers to efficient functioning & loss of data

- Loss of a team with a firm understanding of how government works. Vendors will need to become familiar with and up to date on Utah State law, rule, and UDOH policy in order to move forward with data releases.
- Loss of integration the Office of Health Care Statistics has with UDOH legal and leadership, which would be challenging to replicate if outsourced.

[1] https://www.apcdcouncil.org/state/colorado
[2] https://www.apcdcouncil.org/state/utah

- Having the Office within the State has made data easily accessible to the Health Department, Legislature and for other governmental entities. There may exist loss of collaboration with critical public health offices currently under UDOH.
- The Utah APCD has Medicaid data because it is part of the Medicaid state agency. If outsourced the APCD may lose the ability to house Medicaid data due to federal restrictions on the data.
- OHCS maintains unique and close relationships with the State's 13 local health departments, has critical ties to other state and local public health entities, community health centers, essential public health services and the private health care system. These relationships may be challenging and take time for an external vendor to replicate who may not have the standing of being a state agency.

Privacy and Security Protections and Technical Assistance

- OHCS, as a state office, has a primary purpose of benefitting the public. In collaboration with the Health Data Committee they have convened several committees to address needs of data suppliers as well as protection of the public's information and provide analysis that will benefit the public and inform policy. These committees are convened by OHCS. Some of those committees include:
    - The Utah Health Data Committee
    - Payer Task Force
    - Facilities Task Force
    - Transparency Advisory Group
    - Data Use Subcommittee

Loss of institutional knowledge

- The small team in the Office of Health Care Statistics represents over 66 years of combined experience working at the Utah Department of Health. Vendors may have little to no institutional knowledge.
- Turnover of staff in the consulting industry may inhibit transference of institutional knowledge that grows over time and yields beneficial in understanding the relationships, rules and regulations, and functions of stakeholders who contribute to what ultimately becomes the work of the Office of Health Care Statistics.

EXPLORATION OF HIGHER FEDERAL MATCHING FOR HEALTHCARE STATISTICS PROGRAM FUNCTIONS

In 2017, the Centers for Medicare and Medicaid Services (CMS) provided feedback to modify the current Medicaid Match calculations. In response, the Office worked with UT Medicaid to alter calculation for the Medicaid Match to a formula that CMS would approve.

Presently, the Medicaid match is based on the ratio of Medicaid medical claims contained in the APCD as a proportion of the total number of medical claims. The total operating costs of the APCD are multiplied by this ratio and then the resulting amount is matched by Medicaid at a 50% rate.

The Children's Health Insurance Program (CHIP) match is based on the ratio of CHIP medical claims contained in the APCD as a proportion of the total number of medical claims. The total operating costs of the APCD are multiplied by this ratio and then the resulting amount is matched by Medicaid at a 100% rate.

On April 16th, the Office of Health Care Statistics met with representatives from Medicaid to discuss possibilities for receiving a higher federal match, in response to this request. As Medicaid claims continue to grow, and the proportion of Medicaid claims in the APCD increases, OHCS may see more money from Medicaid for the APCD. However, we were advised that the current formula as approved by CMS is at the maximum currently allowed.

Additional Medicaid funding would only be allowed for additional work, so it would not offset current costs. The team at Medicaid advised that they saw limited to no need for additional products at this time. OHCS will continue to communicate with Medicaid to explore opportunities.

CONCLUSION

At this time OHCS does not see any clear benefit to increasing outsourcing. It is likely that additional funding would be needed to outsource the few tasks remaining that could be outsourced.

Additionally, based on consultation with Medicaid, there is not a possibility of a higher match rate for the current work.