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Health Information Technology: Possibilities and Pitfalls for Policy Development

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Policy Requires Information

- Policy development begins with vision and goals – but these only get policy so far.
- Policies and programs need functioning methods, such as payment systems, quality indicators, and patient outcome assessment tools. These methods (ideally) are analytically based, requiring information.
- Once a policy is implemented, it should also be evaluated and refined based on what works and what doesn't. This also needs information.
- **Access for policy makers to data fueled by Health IT could be a powerful tool to improve health care policy development, implementation, monitoring and evaluation.**

What information is currently used for health care policy development?

Claims Data are the Current Standard for Analytic Policy Purposes

- Most analytically based health care policy tools are based on claims – or 'bills' – for health care.
- Claims analyses are a powerful tool for policy development, implementation and evaluation, but in general they have limitations.
- Claims document what was provided and paid for, but information is confined to benefits covered.
- Claims contain only limited clinical and health outcome information – usually just enough to justify the payment, but not enough to fully describe why certain health care services were provided and what the comprehensive outcomes were.

Current Data for Policy Development: Medicare and Medicaid Claims Data

- Medicare and Medicaid claims are a rich source of data and a major tool for policy research.
- Claims files are generally available for policy purposes, especially for government funded research.
- Medicare and Medicaid claims files includes large populations, allowing often for statistical power.
- But for some policy purposes, information on patient clinical status must be collected in separate assessment tools (such as IRF-PAI, MDS, PAC Care Tool), adding extra provider burden and requiring data linkages to claims.
- No claims are available for managed care enrollees, and data are limited to these insured populations.

Current Data for Policy Development: Proprietary Claims Data

- Proprietary claims data sets are available through commercially developed sources (Thompson - Med Stat, Avalere, etc).
- These sources of data are often limited to specific employers, populations or insurers and may have substantial limitations or include biases when used to simulate analyses for a wider population.
- These sources of data can be expensive to obtain, are not always provided at reduced/no cost for public policy purposes, and access to the actual data (as opposed to consulting services which use the proprietary data) can be limited.

Current Data for Policy Development: Non-Claims Policy Data Sources

- Functional status and health outcome survey data
  - Survey initiatives provide supplementary information on health status, outcomes, and other non-claim information.
  - The MCBS is a good example for Medicare.
  - These surveys are very expensive to implement, have limitations inherent in self-reporting and response bias, and can have sampling limitations.

- Medical record abstractions
  - Policy development can supplement claims information by abstracting additional information from medical records.
  - The process can be expensive and time consuming…not practical for most real-time policy analyses.

How might health information technology improve policy development?

Policy Initiatives and Health IT: Payment System Refinements

- Prospective payment for hospitals, other institutional settings, and managed care is important in incentivizing providers towards efficiency. These payment models require extensive modeling to estimate appropriate payments.
- Health status risk adjustment is used to adjust payment for the predicted cost of individual beneficiaries. Current models are often limited by incomplete data that may lessen the potential accuracy of the models.
- Data derived from health IT could be used to expand and improve the accuracy of payment models, taking into account health status information independent of services provided.

Example: Health IT and Medicare Advantage Health Status Risk Adjustment

- Current Medicare Advantage risk adjustment models are based on predictive algorithms developed using Medicare FFS claims.
- However, since the models are based on FFS claims (there are no claims for capitated plans), the models cannot take into account costs predicted by managed care (instead of FFS) practice patterns.
- Risk adjustment models are limited to co-morbid diagnostic information resulting from services provided and reimbursed by Medicare.
- Building risk adjustment models based on more complete diagnostic and health status information available from health IT systems could vastly improve the power of the models that predict which patients will be most, or least, costly in future years.

Policy Initiatives Improved by Health IT: Payment System Refinements

- Post acute care payment models are currently under refinement to add clinical assessment information to provider reimbursement . However, assessment information must currently be collecting using separate tools then linked to claims data.
- Access to health IT data could refine these models even further, potentially incorporating wider spread use of health status and other assessment information, very expensive to collect through survey methods.

Example: Health IT and Medicare Post Acute Care Payment Refinements

- Post acute care policy development recognizes the importance of patient assessment information for accurate payment models.
- But current methods of collecting that information are fragmented and sometimes paper based:

  Acute Hospitals → no standard tool
  Long-Term Care Hospitals → no standard tool
  Inpatient Rehabilitation Facilities → IRFPAI
  Skilled Nursing Facilities → MDS
  Home Health Agencies → OASIS

- Under CMS's PAC Demonstration's CARE tool, data are submitted electronically via the web:
  - Participating providers can view their assessments and assessments from prior providers treating their patients.
  - Web-based system standardizes the items and language.

Policy Initiatives Improved by Health IT: Development of Next Generation Payment Models

- Provider Pay for Performance development and implementation has often been limited to demonstration and pilot projects because of the cost of gathering and submitting the data required to support quality of care and cost metrics.
- Administrative claims are not currently sufficient to support some of the more sophisticated models.
- Access to health IT data would support the administrative feasibility of the development and implementation of next generation models like pay for performance by making clinical and outcomes data more readily available.

Example: Health IT and Medicare Pay for Performance

- Potential models include various Medicare demonstrations including the Physician Group Practice Demonstration, Premier Hospitals and Centers of Excellence.
- Potentially promising models, aimed at providing financial incentives to simultaneously improve quality and efficiency, are only implementable with providers who have sophisticated data systems and support from government contractors.
- Widespread Health IT investments among providers would make pay for performance models more feasible on a wider scale.

Policy Initiatives Improved by Health IT: Reporting and Monitoring of Health Care Outcomes

- Reporting and monitoring of health care outcomes and quality of care are policy initiatives of significant interest on the theory that purchasers and consumers will choose high quality providers if the information is available.
- However, some of the current quality reporting information is based on measures derived from claims or survey data, both of which have significant limitations.
- Availability and analysis more comprehensive data through health IT could make identification of health care services with clearly demonstrated positive outcomes administratively feasible on a larger scale.

Promise…but still some pitfalls.

Limitations in the Use of Health IT for Policy Purposes: Data Privacy

- HIPPA regulations require that data from health IT systems maintain the privacy of clinical and other personal information.
- Encryption and other data privacy methods will increase the cost and complexity of using health information for policy analysis purposes.

Limitations in the Use of Health IT for Policy Purposes: Administrative Costs

- Administrative data, like claims, are highly efficient for policy analytic purposes because they are routinely submitted, verified and cleaned for payment purposes.
- Health IT information won't be routinely collected as an analytic data set. Gathering, organizing and cleaning the health information for analytic purposes would be a cost to be accounted for.
- Who would pay for collection and development of analytic files of Health IT data?

Summary

- Access to data that derived from health IT systems could vastly improve the completeness of information used to develop and evaluate policy alternatives.
- Data from expanded health IT would enable policy makers to know not only what services were provided and what they cost, but also determine systematically why services were provided, which were the most cost effective, and which were associated with the best evidence based clinical outcomes.
- These are compelling arguments in the face of health care reform where a prevailing goal is to provide cost-effective health care.
- Still, the considerable data cost and privacy issues remain.