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Health and Human Services Committee
December 05, 2011

[LR197]

SENATOR CAMPBELL: I apologize for the late start, but the Health Committee has sort of been on. We had an 8:00 meeting and then a 9:00, so we are kind of running late. I would like to welcome you to the LR197 interim study introduced by Senator Nordquist as an interim study to examine issues relating to the implementation of an all-payer claims database in Nebraska. As is usual with the Health and Human Services Committee, we will do self introductions, and I will start to my far right. [LR197]

SENATOR BLOOMFIELD: Dave Bloomfield, District 17, Wayne, Thurston, and Dakota Counties. [LR197]

SENATOR COOK: I'm Tanya Cook from Legislative District 13, which is the city of Omaha and northern Douglas County. [LR197]

SENATOR GLOOR: Mike Gloor, District 35, Grand Island. [LR197]

SENATOR CAMPBELL: Kathy Campbell, District 25, east Lincoln and Lancaster County. [LR197]

MICHELLE CHAFFEE: I'm Michelle Chaffee, legal counsel to the Health and Human Services Committee. [LR197]

SENATOR HOWARD: Gwen Howard, District 9, Omaha. [LR197]

SENATOR CAMPBELL: And Senator Krist will be joining us, stepped out, but will be returning. I just want to remind everyone, if you have a cell phone, to turn it off or put it on silent so it doesn't disrupt the testifiers. If you plan to testify, you need to complete an orange sheet for the clerk, Diane Johnson, and our page today, who will return, is Alisha (phonetic). She will be back, so if you need something, you can visit with either Diane or

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Alisha (phonetic). As you start your testimony today, please state your name for the record and spell it. How many people in the room plan to testify today? Two, okay, in addition to Senator Nordquist. Excellent. Because there are only two people, we won't use the light system, and with that, welcome Senator Nordquist. We are really glad you're here today. [LR197]

SENATOR NORDQUIST: Right. Right. Thank you, Madam Chair and members of the committee, for making time in your schedule to hear about this issue. I am Jeremy Nordquist. I represent District 7, which is downtown in south Omaha. I appreciate the opportunity to have a discussion on this idea that is somewhat new to Nebraska and is gaining ground nationally. It's an all-payer claims database. I will try to keep my comments brief this morning. We have with us today Denise Love, the executive director of the Association of Health Data Organizations. She is truly a real expert on these issues and many others related to health information. At its core, an all-payer claims database is about transparency of information and data around the utilization of healthcare services. Last night at dinner, Denise used the analogy, "Imagine we are building a top-of-the-line, custom-made Bentley with all the bells and whistles, everything we can throw at it, but then to save a few bucks, we decide not to put a dashboard in it, no speedometer, odometer, or gas gauge." And that is really analogous to our healthcare system where we throw a tremendous amount of money, have great quality services, but we really don't have the information to analyze the decisions that we are making. And like any good policy tool, form follows function, so what an all-payer claims database might look like in our state will depend on how we choose to use it and what our priorities are. I introduced this interim study to examine the potential of implementing an all-payer claims database in Nebraska with the stated public policy goal of providing greater transparency regarding cost and eventually the quality of medical services. In the broader healthcare reform discussion, including last week at the Banking and Insurance Committee hearing, many have raised concerns that while the Affordable Care Act increases access to care, it does not do enough to rein in the cost of care, and the misaligned incentives of the current system remain in place. While

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there are a few opportunities within the Affordable Care Act to look at new ways care is paid for and delivered, there certainly is the common prescription that some people adhere to, and I certainly think we should put stock in that. We need to make sure consumers have better information to make better decisions when it comes to the financial impact of healthcare. So with that, I will turn it over to Denise. Just to give you a little background on her and her organization, the National Association of Health Data Organizations is a national nonprofit and educational organization founded in 1986. It is dedicated to improving the collection and use of healthcare data for market consumer policy and research purposes. She provides technical expertise to and advocacy for statewide healthcare data reporting programs and most recently has been involved in expanding all-payer claims databases working with states around the country to do that. She is a founding member of the All-Payer Claims Database Council. Prior to joining the Association of Health Data Organizations, she was the director of the Utah Office of Health Data Analysis where she oversaw the establishment of the statewide hospital discharge data reporting systems and Medicaid and commercial integrated HMO performance measurement system. She is also a member of many national advocacy and steering committees, so with that, I will turn it over to Denise, and she has a great presentation to share with you today. [LR197]

SENATOR CAMPBELL: Before we start with Denise, oh go ahead, you can come forward. Senator Christensen has joined us. And Senator Christensen, please come up and join the committee. We invited the Banking Committee to join us today, and we did not know you were coming, so we are delighted you are here. Senator Gloor is also a member of that committee, so thanks for coming today. All right, go ahead and introduce yourself and spell your name please. [LR197]

DENISE LOVE: (Exhibit 1) Thank you for the lovely introduction. I am Denise Love. D-e-n-i-s-e L-o-v-e. As Senator Nordquist indicated, I am the executive director of the National Association of Health Data Organizations or NAHDO. I will go through a presentation today that gives you a flavor of what is going on in other states. I think the

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takeaways are that I am going to be talking to you about connecting data dots across the healthcare system and some considerations as you think about what kind of information you need to manage the state of Nebraska and transform your own healthcare system. I just want to assure you that through these state stories and experiences that I will share that you don't have to invent a wheel. The wheel has been invented so to speak, so you can leverage quite a few other states' experiences both in technical lessons learned but also in tools as states go down this road. The other takeaway is that this is an investment. This is a long-term investment. This isn't a turn-key report or system, but what happens is the state that invests in a data collection system today realizes the payoffs down the road. And as we have seen with some states, the payoff can be pretty significant down the road, but it's not an easy build. So, those are my three takeaways, but I would be remiss not to talk about the All-Payer Claims Database Council which NAHDO was a part. All of this information that I provide and a whole lot more is available on apcdcouncil.org and I will have, I think on my last slide, that Web site as well. We have done a series of issue briefs and fact sheets that were funded by the Commonwealth Fund too, and we have populated this site with the latest. As you see this map, the state profiles, as a state releases a report, we update it so you can link to that state and keep current on what is happening. Well, the APCD Council NAHDO has worked with states across the country for over 25 years to develop data policies that are conducive to publicly available healthcare data. We have been doing that work with all the states on this map and hospital associations such as Nebraska, and I know Kevin is here, so we work in data. But in the northeast in 2003, Maine was the first breakthrough. The employers in the state of Maine were seeking data that did not exist on outpatient services. They had their own data systems, but they were trying to put pieces of what is going on between inpatient events and beyond their own experience together, so Maine was sort of the pioneer in all of this. Once Maine started having a successful data aggregation, the other northeast states, Vermont, New Hampshire, took note and followed Maine's path, as did Massachusetts. and now and I'll this story as well. But it resulted in the states working together under the regional All-Payer Health Information Council. Well then states started coming to NAHDO, states

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like Utah, Oregon, Tennessee saying we're not part of that northeast; We're part of NAHDO. So we merged. And so we work as a virtual team on the ground. Part of my team is in Connecticut today speaking to their stakeholders, so we really are on the ground in many states. These are our bio's. We are on the site. We all are there to help states with the myriad of issues and problems. So, I will go over what is happening, what we are doing to harmonize across states, because that is one thing we hear over and over from insurers. If you are going to do this in more than one state, please don't have state-specific formats. I will share some experiences and lessons learned. We shape division for APCD 2.0 that I will lay out there, but as we have health benefits exchanges and health information exchanges and ACA, it has changed the flavor of what we want out of our data system. Again, when Maine started in 2003, none of these initiatives existed, so trying to adapt the policies to meet today's information needs is a challenge but possible for states to do. So again, we are seeing increased transparency. Employer coalitions are seeking more data. We have the payment reform as I mentioned the HITECH and PPACA. So what do I mean when we say all-payer claims databases, because when we think of data, we all think of our own frame of references. But these are databases that are typically not always created by a state mandate. They typically include data derived from medical, pharmacy, dental claims, also with eligibility and provider files that are provided from the public and private payers. Those include insurance carriers, TPAs, pharmacy benefit managers. States are all working to roll in public payers, Medicare, Medicaid, and public employee plans in many states. We do underscore that the hospital discharge data systems that have been built around the country, including Nebraska's, it does not replace. These are two different data systems built for different purposes. So some states have asked us if they could replace their hospital discharge data reporting, and I think it is too soon to say that, because they are again are very different databases, but working together they are quite powerful. I have some examples, so I won't belabor this, but these are just questions that the team early on came up with. And you know, MRI use by provider by payer for certain conditions. Through an all-payer claims database, you start seeing beyond the surgery. You start seeing what ancillary services were provided in a

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particular episode of care and how that MRI might drive the decision to surgery and including the outcome. Geographic variation is huge, and so looking at different area metrics is important. I will have some examples. Employers want to know, of course, the typical HEDIS and preventive measures, but they can start looking beyond their plan and look across the system and seeing how they compare to the whole aggregate of the commercial market in certain metrics. Emergency room uses is a huge issue, and it is not just the Medicaid population. So what are those drivers? Is it geography? In some cases, yes, but understanding what is making the system and the costs look the way they do. Antidepressants, we don't have another window outside Medicaid into what is happening with this burgeoning pharmaceutical utilization, and in some cases, completely appropriate to how it looks in an episode of care, in other cases, it's not, and then traveling for services for outpatients. So this is just a menu of questions, and I will try to get down to some other examples. Well, if Nebraska were to go on this journey, my colleagues and I would tell you don't try to get your whole market put together in year one, because it's just not going to work, nor is it necessary. You really need to be strategic in how you go about something like this so that you can succeed. So the typical road map for this is that a state will look at their insurance market, and they will map out, and I think you have had a report here that has done so, but map out who your large commercial plans are carriers and what share of the market and then start there and start working closely with those payers to assess their capacities, look at what they can provide, test that data and normalize that data because that is the easiest place to start, and it gives you some useful information early on that you can use in your commercial market. Typically then, once states have aggregated the larger payers and not chased every small TPA and every commercial payer, but the bulk of the market, and that threshold will vary in each state. We can talk about that some more, but I am staying out of the weeds a little bit, Medicaid becomes an important data set for the states, and adding the Medicaid fee-for-service, managed care and S-CHIP, and that plays out differently in each state, but the ideal would be that then Medicaid would be mapped to that commercial format so you have a reference database to do some comparative studies. The thing that is causing us the most headache right now are

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Medicare Parts A and B. Now states are getting them, and all states plan to get these data sets, but working through the federal government and CMS is not trivial. It's not cheap. It's not uniform in how CMS is providing the data to states, but through NAHDO and the APCD Council, we are optimistic that we can streamline the request process for states and hopefully improve the lag time, because a state that is having quarterly fees and has updates from the payers typically will get 2- to 3-year old data from CMS, and that makes it really tough to do benchmarks and trends. So we are working with that. That is a long-term to do. And then the piece in the middle, the uninsured, and federal payers, we just recognize up front we're not going after that right now. We have got our hands full with these outer circles. There are work-a-rounds. There are ways on the uninsured, but that is not what this database is built to study right now. What we are looking at is the insurance market, and the uninsured are typically captured in the hospital discharge databases and the self-pay, so that is why they can work in tandem very nicely together, but we don't go into this telling legislators and others that you are going to get all of your population in a data collection initially. I won't go through all of these data elements, but the reason encrypted Social Security is up there and double starred is we need somehow to have uniqueness in the records without raising undue concerns about privacy, so in the northeast, they have a common encryption program they provide to the payers, and that program encrypts in a standardized way that goes into the state agency that is aggregating the data that isn't automatized in the sense that it's not John Smith. Other states are taking a different approach, and that is what I will talk about when we go into HIEs and health benefits exchanges and some other things. We are rethinking how robust that encrypted Social Security number can be if you are trying to link with other data sets and really build an information exchange that is patient centered and follows a patient through the system. And so, that is an approach the northeast has taken, but we have seen the other states adding the patient demographics too, you know, patient name, address. Now, what they collect is not what they release, so it is very different, but it does limit. If you just get an encrypted number or no unique identifier, it limits what you can do with the data down the road. We know that the current all-payer claims databases do not collect data on the uninsured. There

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are exceptions, and there are some pilots, and it is very promising, but that is down the road. Denied claims, we recommend states don't even go there. You have enough to do without having to piece together the denied claims. Workers' comp is typically left out because it's just a different breed, a different animal, different kinds of claims. That doesn't mean it can't be added in or rolled in down the road. Referrals are not collected. The actual test results, that is something we get asked a lot for. We can say the claim is coming through, but the test results are not for imaging. Provider affiliation with group practice and some information on provider networks is not coming through. We have states that are, one state in particular will add premium information. They want that information as part of their APCDs. We understand that capitation fees, administrative fees, back-end settlements are not part of the claims transaction. We do believe there are ways to get those and roll them in an aggregate form down the road as we get better at collecting these data. Well, we are filling in the states. I think we added Nebraska as a state with strong interest, so we do have quite a bit of chatter, I guess, going on about the possibilities, but the dark-colored states are the ones in full implementation. They are on the ground with multiyear aggregation. West Virginia and New York are right in the gates, Colorado as well, so we are really learning, and the APCD Council and NAHDO have this learning network that is set up, and we meet monthly with these states. We share information monthly, and we meet at least once annually to share the latest and greatest. We are working on standards development. The payers have begged for relief. One of the things we feel we can do is harmonize across the state formats. We provide technical assistance and Web resources as I discussed, publications, and issue briefs. The Agency for Healthcare Research and Quality is very interested in the all-payer claims data movement. They have put up five state formats, I believe, on the United States Health Information Knowledge Base, which is a mapping of the standards across those states, but it also is a huge database of data sets across the United States that are collected. I will skip some of this, but our standards panel, our technical advisory panel includes the industry, AHEP, AMA, and CDC and the typical NGA, so we are at the national level quite imbedded with the various groups and try to honor what is going on nationally and try to translate that with

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what is happening locally, because each state, we have a saying, "You've seen one state, you've seen one state," so we try to bridge that gap between the national and the local initiatives. Right now, we are thick in the data collection standards. We are aligning them to HIPAA. We have actually got ANSI X12N work groups working to develop implementation guides for the industry so that we have something to cite. If you have a rule, you will have a time where you can cite the X12N implementation guide. You don't have to write the data elements and rule. Data release tends to be all over the map, because states have different political concerns and different laws that govern, and we can talk about that more, but sometimes the state, for example Minnesota, took a very restrictive approach to data release. The data that they collect from claims will be used internally by designated state employees to do policy analysis, and that's it. Other states have taken a more broad approach where they would partner with researchers and others to make the data available and employer coalitions, and there's a way to do both, and that's a state decision. We like the broad applications, because you will get more out of your data system, but we understand the political. We are developing medi-data, and applications and reporting, I will show some examples, but they are rapidly evolving. We do have an implementation guide for state reporting of pharmacy, so we are real proud of that. That NCPDP worked with us to develop a post adjudicated layout that states can adopt, and it looks the same in Vermont as it does in Utah, so again, standards, standards. We are well down the road, but I don't know. It is pretty boring for most people to listen to X12N talk, so if we want to come back, we will. So, why are they doing this? I mean, why would a state do this? Well, as we talked, the healthcare system is under rapid evolution. We want consumers to get more engaged. Employers are having to make decisions. Their rates are going up. They want to know what they are getting for their money. Health plans are well aware of the value of data, and they do a lot of profiling and a lot of reports within a health plan, but it is a single-payer view of what they are doing, so aggregating that across the system has power. Providers can use it for their own quality and community initiatives. Researchers are salivating for this, and I think every state I have been in, if they have a center for health policy or they have a center of insurance, they very much want these data, and I might add that it makes

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them with the database accessible, those research centers like in New Hampshire and Massachusetts and others are more competitive for grants and different studies and research components, because they have access to a pretty unique and robust database, but I think state government, because I'm from a state and I spent nine years doing information for states, state government is the big winner in this for the use because they have, as Senator Nordquist said, a great need for a robust dashboard and some baselines and information about what is happening across the system. [LR197]

SENATOR CAMPBELL: Denise, can we stop? We have a question here. [LR197]

DENISE LOVE: Yes. Yes. [LR197]

SENATOR GLOOR: Thanks. You now, I got more information than I can hold in my head, and I'm running out of tablet space, so I need to ask a question before I forget. Give me some specific examples of what providers would do with this information and what state government, especially in your experience, does with this information. [LR197]

DENISE LOVE: Well, it depends what arm of state government, but providers have their own information on their experience, but I have spoken to providers across the country who are under a great deal of pressure to reduce readmissions to a hospital, for instance. But I also know that the literature bears out, and some of the APCDs have borne out that only 20 percent, it is either 20 percent of readmissions are not at the index hospital. So you really start putting the pieces of the system together so if Hospital A experiences or is responsible for readmission but that person went across to Hospital C, who is connecting those dots? I'm not sure who is doing that, but that is just one example. [LR197]

SENATOR GLOOR: Can I flip that the other way though and say is there opportunity for a provider to, when in fact that is probably the sort of thing from a quality standpoint and

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a reimbursement standpoint they ought to focus on, they spend more of their time looking at opportunities for competitive advantage. You know, what is happening with another. I mean, it's a two-edged sword. And maybe that's not a good descriptor but. [LR197]

DENISE LOVE: Absolutely, and I'm just thinking of an example here from Fingerlakes Health Services. This is a typo here. I just did this this morning. I was looking through some of the notes from our recent NAHDO meeting. We just met in November in Alexandria, Virginia, and we heard some stories from the field of how they're using it, and I think that is a good question, how would providers use it, because providers do have an information-rich environment, and so they probably are the ones beating down the door the least for it. But, if you look at quality improvement initiatives, what we heard from Fingerlakes who is aggregating data from commercial payers, they feel that there are several things that they can get insight into the outpatient care that they can't get through just provider data systems. And then they can look at pre and post event tracking, and this is where I got the 20 percent readmits to non-index hospitals but you can also when you go to a group of, and I am thinking out loud, which could get me in trouble, but I am following your question here. But if you go to a group of specialists, orthopedics, but I'm just putting...I'm brainingstroming here, and you show them that they have huge variation in cost or outcomes or volume, and as physicians, and I have worked with physicians on quality improvement, they want to improve. I mean, they okay, so tell me what to do about it, because if we are to reduce this volume or narrow that gap to save money, what has to be done? And through the claims detail, you can start, I believe, you can start drilling down a little more and saying this group does X percent more MRIs preoperatively which might explain why more surgeries are done. I mean, this is all hypothetical, but I think it gives you more ways to peel that onion back and have some real conversations rather than there is a ton of maps I have that show variation. We know the system is huge variation in volume. Pick a metric, it will vary across by geography or by pair or by population of interest, but the data don't tell us why that is, and that is where the conversations have to occur within the people who have

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control over those decisions, your stakeholders. And I know from Utah and my personal experience that you bring the information about variation to a specialty group, be it OB or anything else, the data gets them engaged. The data doesn't tell them why we have a four-fold variation between a rural hospital and an urban hospital. It gets their attention. They may not even like it. [LR197]

SENATOR GLOOR: It probably especially gets their attention if they know what their numbers look like versus what the norm or the mean may be for other providers that are in the same... [LR197]

DENISE LOVE: Well, in Utah early on when we did one of these variation reports, we had a hospital medical director just in disbelief, and this is a very common thing. Attack the data. The data can't be right. This can't be right. We can't be comparing this way. And the data are transparent, publicly available. Provide it back, work with them. We ended up with some multiyear quality improvement initiatives and found out that that variation wasn't that hospital's fault per se, it was a structural, but it took several years of naval gazing, I guess, and data looking to realize that the hospitals that are at highest risk for primary C-sections didn't have an anesthesiologist on staff. But it didn't just start out there. But it was the shock awe of having a public discourse about this variation. [LR197]

SENATOR GLOOR: Now let me segue because you were talking about quality. Now take that to our responsibility in state government and how some of that number crunching would play out with quality improvements at the state level, Medicaid specifically. Can you give me an example of how states have looked at that, or are you going to get into that in a bit? [LR197]

DENISE LOVE: I can. We have a load of examples, and I just didn't want to overload you. But here is some just...I can just do some examples. States are looking at their Medicaid population vis-a-vis the commercial and looking at prevalence and looking at

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experience and cost. And so not only now do you just look at your Medicaid data and say, "Oh, we're in big trouble," but you can have a reference of the commercial market, and you can see the disease burden here. For asthma, of course, for Medicaid is much higher than that for commercial. This is another one on COPD prevalence standardized for age between the commercial and the Medicaid populations in New Hampshire. And, you know, you can really start looking at the areas where the burden crosses the populations. Again, this is a study on asthma for New Hampshire Medicaid and commercial and looking at prevalence versus burden. [LR197]

SENATOR CAMPBELL: Senator Krist, Sorry. I was reading. [LR197]

SENATOR KRIST: I'm going to follow along that question, but I'm going to get into relevance and cost. We had a huge concern in Omaha, an entire medical system that has just transferred over to electronic records for their patients. Okay, the data is there. Why would I create another database to show me what the relevant by institution by office doctors treating asthma and they are either paying with Medicaid, or they are paying with private concerns. That information is already there. What we are talking about in this particular case is who is going to do the analysis, and how are you going to pull that information, and potentially, how is HIPAA going to play into all that so that privacy is there or not? So, let's take the example of the Omaha metropolitan area where we have one huge hospital system that is now, everything is on an electronic database. Would you propose then that this kind of analysis, this data or this software, if you will, or this analysis can be done given that data, or are we now establishing a whole new data system? [LR197]

DENISE LOVE: I'm guessing, and I'm just guessing that you are talking about their electronic health record in the hospital system... [LR197]

SENATOR KRIST: R.ight [LR197]

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DENISE LOVE: ...which may or may not talk to their claims system. [LR197]

SENATOR GLOOR: It does. [LR197]

SENATOR KRIST: It does. [LR197]

DENISE LOVE: It does. Okay, which is good. And I am guessing then that they have a pretty robust idea of what is happening in their system, but this would not replace that. I mean, because there is no comparison, I mean, because the other systems aren't in that system. This is not a software. This is a database of a minimum data set that is pooled or aggregated across all the payers in a system of the transactions of the claims. Now, as more hospitals have electronic health records and if those health records are standardized and if they are retaining them in a structured format, you can start pulling in, and I have a slide that shows pieces of information that could enhance the claim, because the claim is just the claim. You are really following the money and the volume and the patterns of what is happening across the system. [LR197]

SENATOR KRIST: And this system that I'm speaking of, if I go into the doctor, I have a diagnosis, he puts a prescription on my record, you know how I am paying, when I am paying, who is paying, how many insurance companies are paying. In my particular case, my primary insurance, my TRICARE, my wife's additional insurance, you have all that on this database. Why do I need this? If I can analyze what information is in the existing database, than why would I go establish another database? [LR197]

DENISE LOVE: Well, I, because I don't know who has access to that database. I mean is it publicly, could the state government do, I mean, you know, so yes, it sounds like a great database, but how comparative is it to those not going into that healthcare system? I mean, if you go to a different hospital in a different part of the state, you know, you are going to get different metrics. So what I am talking about is a minimum data set that is pooled across the whole system. There will be more robust data in the

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systems, in the healthcare [LR197]

SENATOR KRIST: So you could order from this, if this were the state-of-the-art database that we are talking about in this large hospital system that interfaces with payers and doctors' diagnosis and prognosis and prescriptions, you could then say, state of Nebraska, you need to ask all 15 of those individual databases to supply a minimum data set that you then would put into the system and analyze? [LR197]

DENISE LOVE: Yeah. What I'm talking about is setting minimum data policy here for the state of Nebraska, because you're going to have systems that have extremely robust proprietary systems, and that's great. I mean, that makes them do their job better. You don't want to build something like that. You don't want to duplicate what the... [LR197]

SENATOR KRIST: That's my point. [LR197]

DENISE LOVE: You don't want to duplicate that. Absolutely not. You want the systems to be able to have that level of detail to manage your care, make bedside decisions. What I think we're talking about here is what is the state of Nebraska's community database dashboard, what minimally you want. You don't want to duplicate, but you want something that works across the system where you can query or you can draw on those repositories a subset, because I don't want the state of Utah having everything clinical on me. You know, when I'm going...they don't need it, they won't use it. But I do believe the state of Utah wants an idea of what is trending in pharmacy care, how Medicaid pays vis-a-vis the commercial, what populations are getting hurt and by how much. I mean those kinds of pretty broad questions that a clinician might not find that useful except in the sense where we can identify pockets of variation. [LR197]

SENATOR GLOOR: And if I could, and I've been looking for something that metaphorically helps, because it is a complicated issue, but most of the information systems you are talking about that are institution or system specific are designed to

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meet the needs of that organization and are built around replacing the old handwritten medical record with something that is there electronically, but because of bill submission, you know, there's a commonality here of information that finds its way into the broader system, and I mean, I am thinking of communications. It's not an exact comparison, but I am thinking of communications with emergencies and police that are usually built community specific for the needs of that community. If there is an opportunity to overlay statewide with things like 911 so no matter where you are, you can call that and it connects you with the local provider of that specific, you know. I don't know if that helps, but I think when we are talking about being able to overlay some sort of information gathering system, it is to provide that overlay that would allow you then pull out things that might be more specific to the entire state and what is happening in the entire state within that common subset of information that gets submitted outside the needs of that specific healthcare provider or system. [LR197]

DENISE LOVE: I mean this is what is so fascinating working across various states that I like so much, because the questions that you have in Nebraska, you have to decide what are those questions that you want to shape your reporting policy, because you are making data policy, and you know, what are your needs to manage the state, management of care, improve populations. And so those are the things that data can do, or a data initiative can do. It's not the data itself. I'm not selling a system or data. What I'm selling is that the community come together and say what are our priorities? What are our huge needs? What information do we need to know if we are making headway, because we can change a policy, but if we can't measure its impact, it is really difficult. And I have been in states where they have had some wonderful actuarial studies from a consultant brilliantly done, but the first thing the physician specialty groups do is say, and I will leave names off, is well, we don't believe the data. It is a proprietary data set. So, you know, they have their data. It's in a black box. We don't believe that we are 50 percent higher. You know, that sort of thing. So what I am proposing here is not a data or system but a process by which you build a common community data set that promotes, that is transparent, that is, you know, you can

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replicate some studies, and it is again, a multiyear and ongoing, if you're doing it right, process. It doesn't just...it's not an actuarial report you spit out in one day and then go off and do another one. I have so many examples, but my favorite one is the colonoscopy one that I showed to legislators last December, but we can, the Web site where you can post out-of-pocket what you will pay and look at the variation in colonoscopy, and I think it's in New Hampshire, of \$4,000, with \$500 to \$4500, and then it shows what the various components a patient pays. The consumer needs to know these things. I have too many examples, and we can always come back to them, but I am going to show just a couple...oh, and HIPAA was brought up. Because many of these systems, not all of them, but many of them are built under state law, either through the public health authority, a health data authority act, they are not, they are exempt from the HIPAA privacy provisions, so state law really is important. The governance of these is important. We have got the Wisconsin Health Information Organization, which is a nongovernmental voluntary initiative. They are doing wonderful things. They are looking at variation, benefit designs, disparities in care. They don't have state law, so they are not getting all the adjudicated information, so payers are providing the data voluntarily to the WHIO without the state law. They have to execute business use agreements. It is restricted to who it goes to, and they don't get all of the payment information, and they can't compel the payers to report, and they can't compel the payers to correct their data, which is different in other states that have the law compelling, but it also exempts the state from the HIPAA provided, you know, there are restrictions that are at least restrictive and stringent as HIPAA. Fingerlakes does a lot of the quality improvement. Massachusetts is another state that is by statute required to do cost and relative pricing reports. One of the things that they found is they could build utility into an all-payer claims system by doing an inventory across all the agencies of how many reports payers are already providing to the state of Massachusetts, and there's a lot of reports through insurance and other agencies, so they have been working to consolidate that reporting and generate HEDIS measures and other things that payers then don't have to report ten times. Their vision is collected once and used for multiple agency reports. That is possible sometimes, it's not possible others, but that

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a vision in Massachusetts. They found that they were getting some insurance information in Massachusetts. They were trying to do tiered network design, but they didn't have enough data. They were getting aggregate data from the payers, but they couldn't really get into the details, so they are building a central repository, and again, we haven't gotten into health benefits, exchanges, and risk adjustments. [LR197]

SENATOR CAMPBELL: Denise, I've been skipping ahead, and I want to make sure there is plenty of time. If we could go, because a lot of the slides have to do with experiences from other states, if we could go to the lessons learned... [LR197]

DENISE LOVE: Sure. [LR197]

SENATOR CAMPBELL: ...and the components of cost, I mean, I think that is an important part of your presentation that I don't want to run out of time for. So if we could go to that portion, because that is part of what my question has to do with in terms of... [LR197]

DENISE LOVE: See, where, okay, again, and again I will emphasize this is the road map that is where governance and we pretty much have a body of knowledge to guide the state through these different stages of build, you know, governance, building, funding, and analysis, excuse me. Again, components of cost we have learned is not just the population, but how many carrier feeds, how many platforms do you have, and the more the platforms, the higher the cost and setting thresholds accordingly. Again, we talked about analytics and data release. Those are probably the most variable that states have right now. Funding models we can come back to. Lessons learned: You can't do it without partnership with the payers. I mean, the payers are your number one stakeholder, and so you really need to have them at the table and have them engaged, and they will be the key partner. Another thing we hear over and over is transparency and documentation in building the system so everybody is on board and knows what you are doing. Even if they don't like it, they know. There is no secrets. We understand

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that there are limitations to the data. I am being very clear. The data base is not meant to be a clinical decision-making database or any other thing that it was not designed to do. We really think now is the time to seize integration and linkage opportunities with HIEs and health benefits exchanges, and I have a slide to show that. Again, we see a lot of local user analytic consortiums, and this is where regional applications of the data for quality improvement may be the best done at a local level, not the state, so the state is an aggregator, the local users taking it and trying to answer those questions we talked about in their communities. And then, states have to decide, will they do this, or will they outsource it, or will they use an existing agency to do that. Again, we talked about you're not going to get 100 percent of the population, but you can do standardized formats and reduce payer reporting burden. Struggling a little bit with the provider numbers. We talked about adjustments. I'm going to go to APCD 2.0. We think as states develop all-payer claims databases, we are going to see the population of those covered in that data set increased. We're going to see standards. We already are seeing standards. We are seeing states looking differently at patient identifiers and building in the architecture for linkages, and master provider index is important and will be for a lot of things, including Medicaid. I was just thinking the other day, I mean, why would Medicaid, I mean, you know, an all-payer claims database, I can think several things. But, if we are doing payment reform and we're going to do provider reimbursement based on, you know, some incentives built in for the providers, I asked somebody this, how is Medicaid going to know those denominators of that provider to build that incentive? And someone from the federal government said, "Well, the states are going to have to use a lot of shoe leather and cobble together the information, or they could tap into the all-payer claims databases if they have them." So, these are, I think, what we're seeing is these data systems for states that have them are starting to be a workhorse for several things that are emerging. Again, we see linkage opportunities, all HIPAA compliant and done under law and done with, you know, paying attention to patient privacy, of course, but you've got the administrative data flowing through the claims. You've got health benefits exchanges that could tap into that for risk adjustment, because I don't see how else to do it, but, or you can have HHS do it for

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you I suppose down the road. And then, you are seeing health information exchanges with that clinical to clinical transaction, and there could be a time where those patient provider directories could talk to each other and you could pull out pieces of information from each to answer more specific questions about outcomes. We keep track of weird things, you know, who collects direct identifiers, and this is another example of how you can tap into vital records, registries, HIE, APCD appropriately with an oversight board and linkage review process because providers don't want to keep, that provider system you mentioned is being asked to submit to registries. They're being asked to submit to public health surveillance systems. They're being asked to report for quality improvement to employers, and you know, if we can just reduce that burden by having smart queries, and so you have the basic administrative data, but say you want to look at outcomes or know who has got a chronic disease or who is getting diabetes testing and what those tests are, you know, you could smart query or do some linkage down the road and just pull in that information when you need it to that record. So, instead of building, you know, a database for every question. So, we really envision that things are going to come together. [LR197]

SENATOR CAMPBELL: Denise, we have a question. Senator Gloor. [LR197]

SENATOR GLOOR: This may help by way of explanation on some of this, but, and I want to make sure I'm right, and correct me if I'm not, but as an example, when you look at that, an opportunity to identify an influenza outbreak that is starting in a certain part of the state and try and trap it or keep it there and address it there, or worse yet, anthrax outbreak from terrorism somebody is spreading along Interstate 80 as they drive through the state. All that could be addressed and information pulled up very quickly verses last year the department asked me to carry a bill that was called syndromic surveillance, and, you know, it accomplishes the same thing, you will recall, but unfortunately required a specific piece of legislation to try and pull that in; whereas, this with low-hanging fruit, when you get into this sort of a system, it drops out of a tree. I mean, it is one of the things that is already there that can be accessed and used in

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appropriate ways for a public health standpoint as requiring specific legislation and regulation around it for just that tiny subset of all the information that is already out there. Is that a fair representation? [LR197]

DENISE LOVE: It's possible. I don't want to upset my syndromic surveillance epidemiologist friends, and I have many, and their questions are very specific, and they are taking some real-time uncoded data, very resource intensive, and it is important, but they can't sustain, you know, a system that looks so broadly, but what it could do is if they did have syndromic surveillance and they are seeing something but they don't know what it is, you can start doing smart queries. I think of the system where you are seeing pharmacy blips. You know, you can set, I mean, this is what I tell me epi friends is really smart people could do some forecasting and some alerts, but you have more to work with than just that feed... [LR197]

SENATOR GLOOR: Yeah, conceptually... [LR197]

DENISE LOVE: ...and I don't know that it would replace that feed. I'm always very leery of saying that one is going to replace the other, because I'm not sure. [LR197]

SENATOR GLOOR: But conceptually it's an opportunity to better understand having to pass specific legislation to get to information as opposed to, assuming it's appropriate and that it fits, being able to have it pulled out of the system. [LR197]

DENISE LOVE: If the data policy is set right, this would augment any number of those systems, including syndromic surveillance, because they would just have more to work with, and you could take those blips that you're seeing and then do a retrospective study to say what happened here to help with your future forecasting? I mean, I'm a data person. I like to build the databases because the real exciting part are to see the epidemiologists, the statisticians and others build the tools that start forecasting. But I have a clinician who is a researcher, and we were in that real time versus retrospective,

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because you can get in two schools of thought. You know, he said give me three years of good retrospective data, and I'll do a predictive model versus, you know, a little slice of real time information and ask me what is going on. But I still think you might need both, but that's Denise Love's opinion. [LR197]

SENATOR CAMPBELL: So, Denise, what is the cost? You had skipped over the components of cost, and I wanted to go back to the funding models there. [LR197]

DENISE LOVE: Yes. Well, this is my biggest problem. I don't have a pot of money to give you. (Laugh) [LR197]

SENATOR CAMPBELL: But on an average, as you have looked at the states that have gone into this, what kind of funding are they looking at? [LR197]

DENISE LOVE: Well, I would say it's, I want to say it's \$1 million a year, but not all states, and a smaller state with fewer platforms maybe \$600,000, but there are so many variables that the APCD Council and NAHDO have kind of shied away of putting a hard number on it. We have a fact sheet that I wrote that has cost considerations, but it really is driven by the number of platforms. If you've got one payer, but that payer has merged with six different companies and has carved out some benefit, you know, and that company accounts for six platforms. Each platform is the work to get to understand that platform and map it. So then you've got, so the startup is not trivial, and you've got that. Then the other states tell me the maintenance isn't, unless payers are changing everything all the time, which is, you know, then you're in more of a maintenance mode, but then you're shifting to analytics, so your startup costs that were spent, the \$600,000 or \$1 million to build it, then shift to what do we do with it? How do we control access? How much episode, do we buy an episode grouper? Do we outsource analytics to a vendor? So, really, the costs are there. They just shift to analytics versus just aggregation, and analytics are the wild card, you know. [LR197]

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SENATOR CAMPBELL: If national healthcare, I mean, we go through the whole thing, and it stays in place, what effect will that have on what, of what the benefit would be to this, and is it going to have any effect or really it doesn't. [LR197]

DENISE LOVE: Well, it might have more effect, because there is several things in that, you know, the state has the risk adjustment that is state specific. You could end up with HHS using a national sample to do a Nebraska risk adjustment for your payers. I mean, that's a possibility. As I understand it, you know, access is going to increase, but there's not a lot of cost controls. You're on your own for that (laugh) so I think you're...and states are going to come up, as states do, with solutions that fit that state, but again, you're going to have to work with the physicians and providers, and I don't know any other data source to do it. You can do it with a single Medicaid database, but all they're going to tell you is that you paid too little. I think you just, you start aggregating the data across the physician and group level data and start engaging the physicians, because they are going to have to help you solve the problem. It's not going to be done by the state. [LR197]

SENATOR CAMPBELL: Okay. I'm going to take questions, and then we will go to the next testifier. Senator Howard. [LR197]

SENATOR HOWARD: Thank you, Senator Campbell. In listening to this, I am wondering how the current system that we have, the NeHII system, Nebraska Information Services Health Insurance system works. Will that interface with this? Would they be comparable, or is there some sort of... [LR197]

DENISE LOVE: ...not knowing... [LR197]

SENATOR HOWARD: Oh, you don't know the NeHII system? [LR197]

DENISE LOVE: I know about the NeHII system, but I would have to be... [LR197]

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SENATOR HOWARD: Oh, well then you may not be able to... [LR197]

DENISE LOVE: I would have to be very careful, because I don't know what is going through that system. It may be clinical information from provider hospital A to provider hospital B, but it may not be aggregated, and so what I'm talking about is, you know a pooled across system aggregation. Now, in other states, they are planning on using their health information exchange to pull in clinical information as it comes through that exchange, but it has to be thought through what clinical information, because... [LR197]

SENATOR HOWARD: The NeHII is entirely voluntary on the part of the patient. [LR197]

SENATOR CAMPBELL: And that is the next testifier, and I am trying to get to that person so we make sure that we have enough. [LR197]

DENISE LOVE: Yeah. So they would be able to tell you more about that. [LR197]

SENATOR CAMPBELL: Senator Bloomfield. [LR197]

SENATOR BLOOMFIELD: Thank you. I want to go back a little bit to Senator Campbell's question on the funding models. See, one of the things you have up there is fines for noncompliance. In determining whose money tree we're going to trash, who determines who pays what fine, and how does that all work? [LR197]

DENISE LOVE: Okay, and having worked under the Utah Health Data Authority Act, I know that very well. Typically, the pieces of legislation they have in place have the authority to collect, have the privacy protections in and have the compelled reporting, whatever that reporting is. Fines for noncompliance are a poor way to fund your data system, and I know very few states have funded the data system based on noncompliance. However, it's a masterful tool to make everybody have a level playing

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field. So, that my big payers who are compelled to report know that they are going to be held to the same reporting standards as some smaller player that is also required to report, so someone can't hide and say I'm not going to report, or I'm only going to report half the data elements. We decide what the level playing field is, and the fines are more of a carrot stick approach. [LR197]

SENATOR BLOOMFIELD: Who is the we besides the... [LR197]

DENISE LOVE: The data suppliers. The data suppliers. So, how it played out in Utah, we had a few hold outs in hospital reporting in the early days. We never fined them, but it was the treat of fines, and I know today they have some similar hearings for the payers. There are some national payers that are not providing data to the Utah all-payer claims database, so the real goal is to work with them. Why? Why not? How can we make this happen? I don't like this fines for noncompliance as a funding model, but it also is...it's more of a tool to make sure that everyone is playing by the same rules. [LR197]

SENATOR CAMPBELL: Senator Krist, did you have a question? [LR197]

SENATOR KRIST: More a comment. I guess the next thing I see is if we move forward with this without really thinking out the piece of legislation and who has to report and who doesn't report and how we collect it and how we assimilate it. The next thing we're going to do is every hospital and every hospital system and every provider and every payer in the state is going to walk in and say, "Great. Another man power. More man power. You are telling me I need to start reporting that," which is why I make the point earlier, if there's already databases in place, and what we're talking about is creating database from some of those extracted pieces of information that are out there, it makes sense, particularly when we are talking about the possibility of having to have a statewide exchange, because realistically, the numbers we're hearing is that the insurance and care in Nebraska costs less than many, many, many other states. So if

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we're asking our folks to go compare to somebody else's payer base in order to establish an exchange rate, we're in trouble, because we're already down, if you follow that logic. Anyway, thank you, Chair. [LR197]

SENATOR CAMPBELL: Denise, if you would stay around for a little while, if we have any additional questions, but I want to make sure I get the next testifier in. [LR197]

DENISE LOVE: Thank you for this opportunity. [LR197]

SENATOR CAMPBELL: Thank you very much. Our next testifier please. Good morning. [LR197]

DEB BASS: (Exhibits 2 and 3) Good morning. I'm Deb Bass, D-e-b B-a-s-s, and I am the executive director of the Nebraska Health Information Initiative, which is the statewide integrator for health information exchange in the state of Nebraska as designated by Governor Heineman. Good morning. Thank you for this opportunity to comment on the topic of the potential benefits realized by the implementation of an all-payer claims database for the state of Nebraska and how the existing functionality of the Nebraska Health Information Exchange or NeHII could support this effort. My beginning statement will be an excerpt from a September 2010 issue brief released by the Commonwealth Fund and written by Denise Love, William Custer, and Patrick Miller. We didn't know that we were going to be playing so well off of each other. I would be happy to provide the brief in its entirety, should you desire, as I found it to be a comprehensive discussion of the topic at hand, but I would like to please allow me to read from this document the portion that addresses the topic of APCDs and health information exchanges, as it is very applicable to what we are going to be discussing. APCDs and health information exchanges. Health information technology and health information exchanges, HIEs, have the potential to enhance existing databases with clinical information for quality and outcomes reporting. Sixteen states and qualified state designated entities will be funded to build capacity for exchanging clinical and other

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relevant information among and between healthcare professionals and hospitals with the purpose of improving the coordination of patient care. While it is unlikely the HIE initiatives will be fully implemented in the near term, and it is likely that HIEs and APCDs will be distinctly separate initiatives, the American Reinvestment and Recovery Act's HITECH provisions may provide unique opportunities for states to build local information system capacity to meet state information needs. It is not too late to formulate a vision for the future. Integration of APCDs and HIEs; the electronic reporting of APCD data establishes a foundation on which states can build. Some experts believe that every state should implement an APCD reporting system and then build on it by strategically enhancing the basic data with clinical information as it becomes available. Integrating APCD data with clinical transaction data will provide robust data for comparison (sic) effectiveness research and population health applications. One of the challenges states will face is the fact that there are few examples of such integration, but integration will eventually be important in improving the usefulness of the data for risk adjustment, clinical studies, and outcomes research. So conclusions, and this is still from this brief, all-payer claims database initiatives are increasingly becoming an important component of state healthcare reform activities serving as sources of information for transparency, value purchasing, and market applications. States with APCDs are well positioned to respond to healthcare reform challenges and to be active participants in comparative effectiveness research. And state HIE development is expected to allow states to enhance APCD data by integrating it with the clinical transaction data. The APCD environment right now is a dynamic one. Challenges to the APCD implementation remain and states benefit from sharing best practices in addressing these challenges. Through the collaboration of their state partners, NAHDO and RAPHIC, which Denise referenced, have laid a foundation for multistate collaboration that will serve as the basis for standardizing systems and improving market and policy information in states with APCDs. And that's the information I wanted to share from this issue brief. Now, with these comments in mind, I would like to talk about NeHII. NeHII, I would like to add that NeHII has placed the state of Nebraska in the national spotlight because we are recognized as a leader in the country for the work we have done with the

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implementation of health information exchange. Since 2009, NeHII has been the accepted infrastructure and designated by the Governor as the statewide integrator for the exchange of clinical information at the point of care linking the healthcare industry throughout the state and improving the quality of patient care. A public/private nonprofit collaborative, NeHII is owned and operated by healthcare professionals and industry in Nebraska and works closely with the state of Nebraska on many common objectives. NeHII recently connected to the state of Nebraska immunization registry allowing providers to electronically send immunization information to NeSIIS, the state registry. We are also beginning the implementation effort that will enable public health reporting and syndromic surveillance activities via our Discover Reporting utility and reporting tool. Yes, we do do data aggregation. The Discover Reporting utility accesses NeHII's clinical repository, a federated system of EdgeServers storing lab results, radiology reports, transcription reports, medication history, problem lists, eligibility files and continuity of care information. I will refer to this Slide 11. The blue is what NeHII provides. Having this data available in real time not only aids providers at the point of care but also provides a significant source of data for such activities of disease registries, research, and quality analytics. NeHII's proven infrastructure, its mission and vision, and its collaboration with the state of Nebraska can make it an ideal partner for the state of Nebraska to implement and manage an all-payer claim database. NeHII is a nonprofit organization and already partnering with the state on healthcare initiatives. Therefore, the question of a governance model for an APCD has already been established with the proven model for success through a public/private collaborative comprised of a vast array of stakeholders from across the state. Another major obstacle to the creation of an APCD is the cost required for implementation. A significant portion of the infrastructure development cost for an APCD can be minimized through the use of the existing NeHII infrastructure. NeHII has also written privacy and security policies that address the access and use of personal health information, another major obstacle to the implementation of an APCD. NeHII offers a robust reporting tool that would allow the state to link the new APCD containing administrative data to the NeHII repository of clinical data to create a wealth of value to researchers and providers. We are a query

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model that Denise referred to. NeHII is also creating connections with hospitals, payers, and providers across the state that can be reused to exchange administrative data reducing redundancy and speeding implementation. All these attributes and the spirit of collaboration present on the NeHII Board of Directors could make NeHII the logical partner for the state of Nebraska in this endeavor, and we look forward to assisting the state in any capacity that we can. I do want to comment on the second handout that you received. It is called our NeHII Fact Sheet, and it is just a document that we release on a weekly basis that indicates the progression of the health information exchange. If you'll look in the third box, you will see the current list of participants as well as those that have signed participation agreements and are pending implementations within the next 12 months. When all of this is complete, we will have 66 percent of the hospital beds across the state of Nebraska that will be providing the information. And also, at the bottom of that document, you will see some of the statistics about the kinds of information that we have that is available for the users of NeHII and the health information exchange. That wraps it up for my prepared comments, and I would welcome any questions. I would also like to comment that I brought the project manager with me, Chris Henkenius, who is in the back of the room. If we get into technical questions that I'm not comfortable with, I might refer to him at times if any of your questions involve that. Thank you for this opportunity. [LR197]

SENATOR CAMPBELL: Senator Krist. [LR197]

SENATOR KRIST: Does the Alegent system (inaudible)? [LR197]

DEB BASS: Yes, it does. Alegent was a leader in NeHII. [LR197]

SENATOR KRIST: And that essentially has been my comment all along, that if it is already being established and if you're doing analytical data, then the next step is to employ the existing data systems in place in the state. Thank you very much. [LR197]

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DEB BASS: Very good comment. What we talk about with health information exchange is we focus on interoperability. Alegant has an EMR, electronic health record, but they are in a silo, so with NeHII focusing on interoperability, we work (inaudible) as the connecting infrastructure so that we can share this information across all of these systems. [LR197]

SENATOR KRIST: Thank you. [LR197]

DEB BASS: Thank you. [LR197]

SENATOR CAMPBELL: Other questions from the senators? This has been particularly helpful. You know, I've heard we have had NeHII mentioned in testimony over the last couple of years, but I don't think that we ever had you come and really give us a basic understanding of how it operates, so this is very helpful, because you can readily see, and believe me, I don't think anybody here except for Senator Gloor, might be able to get into the technical. That we would need to bring somebody in the front. We are still kind of way up there. But this is particularly helpful, and with the pending implementation, then you really start reaching across the state. [LR197]

DEB BASS: Yes, and we have others that are waiting. Blue Cross Blue Shield is already a participant. They have been at the table since 2005. They understand the importance of having this information. They have been a very much valued partner. But just so that you understand, we are a query model. We are not a central data repository. We use federated EdgeServers, but we can query our system to bring this information out and do data analytics that they are talking about. [LR197]

SENATOR CAMPBELL: Has the Department of Insurance, have you had conversations with them in relation to developing the Nebraska exchange? [LR197]

DEB BASS: We have met with them. Again, they are on the administrative side, and our

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task is to connect the clinical side. That is truly the vision of NeHII, and the board of directors has made it very clear, we have limited dollars and limited resources, but we continue to meet with them to keep them apprised of the work that we are doing.

[LR197]

SENATOR CAMPBELL: Good. Because of the hearings that the two committees, the Banking and Health Committee have had, it would be particularly helpful for the senators, I think, to continue to have information about your dialogue with them on a Nebraska health exchange. [LR197]

DEB BASS: We will gladly make ourselves available at any time, Senator. [LR197]

SENATOR CAMPBELL: Excellent. That would kind of round out some of the questions that we certainly have asked at those joint hearings. Senator Bloomfield. [LR197]

SENATOR BLOOMFIELD: Does the information that NeHII minds or keeps, can that be tied back to an individual? [LR197]

DEB BASS: You know, now you're talking about privacy and security policies. NeHII is leading the country in the work that we have done in this. There is, first of all, there's also, there's the topic of the identified data that is tied to the individual, but I can tell you that health information exchange is quickly getting to secondary use of data which is de-identified, which is where we get into the quality analytics, and we are currently working on policies to address that to make certain that we are protecting the information that needs to be protected so that it cannot get back to the individual. As far as health information exchange, our policies have been vetted through the Center for Democracy and Technology. The ONC, the Office of the National Coordinator, uses our policies as examples for other states. The state of Arkansas has even credited NeHII when they published their policies, they credited NeHII for the leadership and the work that we have done in sharing our policies with these other states so that they can get up

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and running sooner. [LR197]

SENATOR CAMPBELL: Question. Do you, who has access to be able to utilize the query system? [LR197]

DEB BASS: Currently, it is just for healthcare providers. It was written for treatment and payment purposes, and now the policies have been expanded to public health reporting because of the mandates coming from the ONC, but we do monitor that access. Every click is audited, which is interesting, because as you know, in the world of paper, we don't always know who is seeing what information. And we work diligently. We have a privacy and security committee that reviews these reports, and we have taken action when we think someone is improperly accessing the information. We also have alerts when we think someone is looking for something. The system alerts us. So, I will also comment, we also are using NeHII for the state PDMP, the Prescription Drug Monitoring Program. It's one of those here it is, and it's looking out of the box at using something that is in place and what can we do to tweak it a little bit to answer some of these other needs. [LR197]

SENATOR CAMPBELL: Okay. Senator Gloor. [LR197]

SENATOR GLOOR: I just want to make sure by way of definition, audited doesn't mean that somebody actually looks at it. What it does mean is it's tracked back to who made the query so that if necessary, you can go back and find out whose computer terminal it came from, as an example. [LR197]

DEB BASS: Right. [LR197]

SENATOR GLOOR: Is that right? [LR197]

DEB BASS: Very good point. I apologize for that. That is what we in the technology

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business when we are talking about auditing, it is knowing who has looked at what information in every port, but you're right, it is not tied to the individual. [LR197]

SENATOR CAMPBELL: Senator Howard. [LR197]

SENATOR HOWARD: Thank you, Senator Campbell. I'm so glad you mentioned the Prescription Drug Monitoring Program which we worked on last year in my bill that was passed. So in addition to these participants that you've got listed here, what pharmacies are participating? [LR197]

DEB BASS: Our pharmacy information comes through the PBMs, the pharmacy benefit managers. So, but it's interesting. We also had Walgreen's that did a site visit here, and we are one of the first states that is using health information exchange for PDMP, and we are now getting interest from other states. Again, one of those "aha moments." Wow, it's right here. Why are we building another separate system? [LR197]

SENATOR HOWARD: Exactly right. Exactly right. So that it has been well received? [LR197]

DEB BASS: Yes. [LR197]

SENATOR HOWARD: And you feel that it's doing what I personally expected it to do? [LR197]

DEB BASS: Feel free to visit with Joanne Schaefer. I have included her on the conversations now with Walgreen's, and we have several calls coming up in the next week talking about some of the other organizations that are coming to the table, the national organizations that are talking about, "Wow. This is a great idea. Let's see how we can expand this." [LR197]

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SENATOR HOWARD: And actually, I have talked to Dr. Shaefer, and she is pretty enthusiastic about it. [LR197]

SENATOR CAMPBELL: Senator Krist. [LR197]

SENATOR KRIST: So one last point of clarification. You are a query system meaning that you ping, and you get information. [LR197]

DEB BASS: Right. [LR197]

SENATOR KRIST: In a depository system, they're going to have a mandatory reporting of certain items that would fit into your database. Is it absolutely necessary, in the techno world, is it absolutely necessary to have a depository system, or can we do what we need to do with the query system? [LR197]

DEB BASS: What we are going to do is de-identify the data and build the registries and the aggregations of data, and again, it depends on the, you have to define what it is you're looking for. But for much of this information, for instance, comparing the costs, once we integrate with the administrative data, and we already offer clearinghouse functionality through NeHII, so we are beginning to get there, and then we can begin to build the aggregation so that we can query it and look at these analytics that the all-payer claim database is talking about achieving. But it's still...it's a ways down the road, you know, and I want to be very honest, but I think there is great potential there. [LR197]

SENATOR KRIST: Thank you. [LR197]

SENATOR CAMPBELL: Okay. Thank you very much for coming today and providing the information. Next testifier, we do have a next testifier. Diane, did you get her an orange sheet? I saw you walk away from it. That's why I asked. [LR197]

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KEVIN CONWAY: Good morning. My name is Kevin Conway, C-o-n-w-a-y. I am the vice president of health information for the Nebraska Hospital Association; and I don't have prepared comments this morning. I just wanted to address some things as you have talked through, so I appreciate the committee's time, and I will try to be brief knowing that we are coming up on the hour. There is a value of these databases. The Nebraska Hospital Association for a little bit over 15 years now has collected what is called discharge data. It may be misnomer. It is actually all inpatient and all outpatient hospital data. We use it for a variety of services that we have heard talk about at this presentation, so there is a value for these type of endeavors. What I want to caution the committee at is how they forego and start putting these endeavors together. We have had great experiences in this state with public-private partnerships. NeHII is a very good example. The Nebraska Telehealth Network is a very good example, and I would even say the discharge database that we at the Nebraska Hospital Association maintain is also a good example at this point. They work because it gives the organization a little bit of nimble feet to make changes to need what they need to address. It also helps the state in not having to burden themselves with financing it and trying to make it off of the funding fees, because a private organization is a little more adept at selling the data for research purposes or supporting outside endeavors, so I want to caution that they are complex. I think we are getting closer to the day when we are George Jetson, and we can just walk to work and push a button and start our day, but despite the belief that systems do work and work well seamlessly all the time, they do need to be maintained, so I think in a private organization, a public-private partnership like NeHII, you do have that capability of being able to make those changes without going through regulatory changes or legislative changes. The other thing I want to caution about is focusing on what type of data, and we have heard some of that discussion. Really, when you look at these type of data systems, they can be categorized in two main camps. One is claims data, whether you are talking about hospital bills, pharmacy bills, physician bills. That is really claims data, and claims data should be recognized as just what it is, what is being paid for, what is the financing of those services. The other camp of data is what's called

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clinical data, and that is where organizations like NeHII have the capability. Claims data will not include clinical information. NeHII has the capability of capturing some of those clinical data elements that may be valuable in these endeavors. Lab results are probably a good example, or A1C test results are a good example since diabetes is probably one of the number one chronic things that we need to be addressing in Nebraska, so I think when we look at these data systems, we need to be focusing on what type of data we are collecting. Luckily, a little bit of ground work has already been done. The Nebraska Information Technology Commission, NITC, had a public health work group that ran its course. I don't remember when it finished it, probably 2008-2009 time period, but they actually issued a report that talked about what do we need to do for these type of endeavors in Nebraska to help support our population. They recognize the things like syndromic surveillance. These all-payer claim databases are great, but they're an after-the-fact claims has been paid, you may get it down to where there is a 90-day lag, but it's still a 90-day lag. If you are looking for flu outbreaks, that's not a good example. Exchanges like NeHII are a good example. If you want to flag something and say, okay, we're looking for this type of specific results, we can flag those and know relatively soon if there's a shigella outbreak or something like that. [LR197]

SENATOR CAMPBELL: For the record, state your name and spell it. I know the clerk is going to need that, and also, the orange sheet when you're finished. [LR197]

KEVIN CONWAY: Okay. Kevin Conway, and it's K-e-v-i-n C-o-n-w-a-y, and thank you. I will complete the orange sheet. [LR197]

SENATOR CAMPBELL: Thank you, Mr. Conway. Questions from the senators. Oh, sorry. Senator Gloor. [LR197]

SENATOR GLOOR: Kevin, I'm assuming what you're saying is the Hospital Association is supportive of efforts to continue moving and looking in this particular direction. [LR197]

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KEVIN CONWAY: You know, globally, I would say an all-payer claims database, while getting specifics designed is really to improve population help for Nebraska, and we are definitely in support of that. [LR197]

SENATOR GLOOR: I'm also curious knowing that the NHA has been doing collection, at least in some capacity, for 15 years. Over that 15 years, there has also been a proliferation in the number of freestanding surgery centers, imaging centers, you know, diagnostic centers overall, doc-in-the-boxes and so on and so forth. So, none of that information is part and parcel of what the NHA is involved in with its members only. Do you have any idea of just roughly what percentage of data out there is not flowing through what the NHA looks at? [LR197]

KEVIN CONWAY: Rough percentage, I was just guessing, Senator Gloor. Knowing that the outpatient ambulatory volume that flows to freestanding centers and physician services probably is a magnitude of 10-20 times what flows through even a hospital outpatient, and a hospital outpatient is about 12 times the magnitude of hospital inpatient, so what we have in possession of the NHA database is just a small pie of what is the total, you know. [LR197]

SENATOR GLOOR: Yeah. I think there is some misunderstanding sometimes that a lot of care is provided in hospitals overall, but I think that is a good example of, you know, it's a small sliver of all the services provided and paid for (inaudible). [LR197]

KEVIN CONWAY: Yeah. Your mentioning ambulatory surgery centers is a good example of trying to address this early on. There was a bill passed in 2003 to have a mandated reporting for ambulatory surgery hospital based and freestanding based. Regulations were written. A system was implemented. We had one report out of the system at this point, which is 2006 data. We are still waiting for the 2007 data report. Obviously, that is not going to do anybody any value at this point. So, again, it's one of

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those things where a public-private partnership is much more nimble at getting those reports out and getting the usable data out to the users quickly. [LR197]

SENATOR GLOOR: Good example. [LR197]

SENATOR CAMPBELL: Any other questions? Thank you for coming today. [LR197]

KEVIN CONWAY: Thank you. [LR197]

SENATOR CAMPBELL: Any other testifiers in the room? Senator Nordquist, would you like to close on your study? []

SENATOR NORDQUIST: Well, thank you again. I know you guys have a very busy day. I just want to thank Denise Love one more time for coming in, and I think what this comes down to is I think we can probably all agree that the cost of healthcare, whether that is for us as individual consumers or business that are paying for health insurance premiums for their employees, or for us as state policy makers through Medicaid is not as transparent as it could be and should be, and I think that this is a way for us to begin a discussion about making it more transparent and getting the information we need as policy makers to make decisions at our level, but also for those businesses and ultimately for consumers too. I know there is a lot of alternatives put forward, opposed to the...people opposed to the Affordable Care Act who have put forward consumer-driven approaches to healthcare. I don't disagree with those, but there is no place for consumers right now to get any kind of information. How can they make those consumer-driven choices? So that certainly, in this discussion, is probably a ways off before we get to that level, but it has to start with the collection and analysis of claims data, so I look forward to working with you and certainly all the partners that have testified here. We have great models and great partners in NeHII and the Hospital Association, and I think we can begin a discussion about how we move forward with this. Thank you. [LR197]

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SENATOR CAMPBELL: Thank you, Senator Nordquist, and with that, we will close LR197 for the day. Thank you. [LR197]