**Democratization of Health Data, Information, and Policy Analysis**

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### I.    Executive Summary[*]

The thesis of this paper is that the lack of a comprehensive health data, information, and policy analysis infrastructure hampers the ability of policymakers in New York to improve both the healthcare delivery system and health outcomes for individuals. By contrast, Massachusetts has had a comprehensive infrastructure of this type for more than a decade. New York could rapidly improve its own infrastructure by using the Massachusetts model as a detailed road map for changes in New York.

We are using the term "health data" to refer to raw data that is reported to or shared with governmental entities, or quasi-governmental entities such as the regional Qualified Entities (QEs) that supply data to the Statewide Health Information Network for NY (the SHIN-NY) and its parent organization, the New York e-Health Collaborative (NYeC). Health data encompasses everything from detailed claims and payment data from payers and providers to patient level clinical data.

We are using the term "health information" to refer to categories and concepts that are meaningful for the analysis of healthcare operations and the evaluation of policies (e.g., expenditure trends, the case mix index, etc.) that have been derived from raw or "unrefined" health data.

In Massachusetts, two governmental entities and a private data consortium comprise the three legs of the health data, information, and policy analysis infrastructure stool. The most important of these entities is the [Center for Health Information and Analysis](#) (CHIA), which has the statutory authority to collect a wide range of raw data elements from the most important participants in the health care delivery system, including hospitals, behavioral health providers, and long-term care facilities, as well as a significant amount of data from commercial insurance plans and public payers. CHIA converts this data into well curated and intuitively presented health information to present a comprehensive picture of the most important aspects of the Massachusetts healthcare delivery system.

The Massachusetts Health Data Consortium (MHDC) is a private member organization that is complementary to CHIA. MHDC was founded in 1978 to perform the data analyses that CHIA performs today. At the time, no state agency was charged with analyzing health system data. MHDC was created to be a neutral third party (i.e., not a provider or payer association) to perform this work. Today, MHDC uses the case mix data and other information that CHIA

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collects from hospitals to assist hospitals in conducting further analyses as part of their strategic planning efforts. MHDC also serves a valuable role as a convening organization of health data stakeholders to address data governance and other issues that require coordination and collaboration.

MHDC facilitates access to information from CHIA and combines it with third party data, especially from the Lown Institute Hospitals Index, in order to further refine CHIA information into a user friendly and even more comprehensive dashboard of health information for strategic planning and other purposes. MHDC and a private analytics firm developed an analytical tool called Spotlight Analytics which hospitals and other members of the consortium use to benchmark their performance across a wide range of metrics.

The Massachusetts Health Policy Commission (HPC), along with a re-purposed CHIA, was created by statute under Chapter 224 of the Acts of 2012. HPC and CHIA are independent agencies, although CHIA is part of the HHS Secretariat, and have an organizational structure that is analogous to a public authority in New York. HPC has an 11-member Board of Commissioners, two of whom are ex-officio, three of whom are appointed by the Governor, three by the Attorney General, and three by the State Auditor. CHIA has an 11-member Oversight Council, four of whom are ex-officio, three of whom are appointed by the Governor, two by the Attorney General, and two by the State Auditor.

The organizing principle of the HPC in 2012 was the establishment of an annual total health expenditure growth target for Massachusetts. Although the health expenditure growth target continues to be the organizing principle for HPC, the analytical and policy work done by the HPC is also applicable to the goals of measuring access and achieving efficiency to promote the financial sustainability of providers in the health care delivery system.

Our view is that the issues of affordability and access/provider financial sustainability are really two sides of the same coin. In New York, given the primacy of concerns related to access and the financial sustainability of providers, a permanent health policy research entity should focus on analysis of health issues with a governance and staff infrastructure similar to the HPC, but with an explicit objective of addressing not only affordability, but also access and financial sustainability.

A permanent health policy research body in New York would be complementary to, and not a substitute for, a temporary Healthcare Delivery System Reform Commission of the type described by Governor Hochul in the 2022 State of the State. A temporary Health Care Delivery System Reform Commission, the planning for which reportedly is well underway, could focus on a strategic vision for the health care delivery system while also making recommendations for near-term tactical decisions. The temporary Healthcare Delivery System Reform Commission could identify specific areas that require long term and/or more in-depth research to operationalize the vision of restructuring of the health care delivery system, which a permanent health policy research body would have the time and manpower to undertake.

Developing the type of health data, information, and policy analysis infrastructure advocated in this paper is not an immediate solution to a short-term problem. Rather, it is about creating a permanent infrastructure that will improve the health care delivery system in New York for

condition, of facilitating the far-reaching structural changes that are needed to ensure a strong healthcare delivery system in New York.

Implicit in the emphasis we are placing on having this health data, information and policy analysis be transparent to the public and user friendly is the conviction that *democratization* of the analysis of this information will produce better outcomes than an opaque system understood only by a few State policymakers and large stakeholders.

This paper concludes with high level recommendations regarding changes needed in New York to rapidly develop a health data, information, and policy analysis infrastructure similar to that of Massachusetts. A future paper could address the specific statutory, regulatory, and organizational structure that it would require.

Appendices A and B to this paper include a detailed crosswalk between the health data available to the CHIA and whether comparable health data is available in New York, and also provides a comparison of the health information that is produced by CHIA, by virtue of their data, and whether that information is available publicly in New York.

## II. Introduction

It may be apocryphal that Mikhail Gorbachev once said, "before you can have *perestroika*, you must have *glasnost*." But there is a lot of truth to the proposition that before you can effectively restructure the system, you first must have openness and transparency, so you understand the problems you're trying to fix.

The premise of the Step Two Policy Project is that by understanding the system and presenting fact-based analyses in support of policy recommendations, we can positively contribute to policy reforms in New York. With that in mind, it made sense to us to begin what will be an ongoing series of papers on health policy in New York by addressing the need for increased transparency of health data and the enhanced communication of useful health information based on that data.

As described above in the Executive Summary, we are using the term "health data" to refer to raw data that is reported to and shared with governmental entities, or government-adjacent entities such as the regional Qualified Entities (QEs) that supply data to the Statewide Health Information Network for NY (the SHIN-NY). Health data encompasses everything from detailed claims and payment data from payers and providers to patient level clinical data.

We are using the term "health information" to refer to categories and concepts that have been derived from raw or "unrefined" health data that are meaningful for the analysis of healthcare operations and policies, such as health expenditure trends, the case mix index, and a wide range of other metrics.[i]

When we talk about "democratization", we are referring to the goal of making health data and information easily available to policy analysts, healthcare stakeholders, and other members of the public, so that they can do their own analyses. Such a democratization would be important even in the absence of new analytical tools, but advances in machine learning and generative artificial intelligence (AI) greatly expand the potential for the development of important insights

if the data and information necessary to build analytical models for AI are made widely available.

New York State government regulates a healthcare ecosystem that is roughly $300 billion dollars in size, but compared to best practice states such as Massachusetts, policymakers in New York are forced to fly the plane relatively blind. It's impossible to quantify the opportunity cost in terms of access, financial sustainability, and affordability that results from this lack of a comprehensive health data, information, and policy analysis infrastructure in New York, but our belief is that the cost is substantial indeed. It is interesting to note that in 2022, New York's overall ranking in [America's Health Ranking Annual Report](#) was 23rd. This is lower than four of our five bordering states. Those four neighboring states that ranked higher all have a more robust health data and information infrastructure than exists in New York. These states include Massachusetts (second), Vermont (third), Connecticut (fourth), and New Jersey (13th).[ii]

When CHIA was established in 2012, its primary goal was to centralize the health data collection and analysis efforts across multiple state agencies, give the government a single point of access to objective health data and analyses. In contrast, health data and information in New York are often inaccessible, even when the underlying data theoretically is publicly available. In part, this is because responsibility for the collection and presentation of health data and information remains siloed among multiple State agencies that share regulatory oversight over the New York health care delivery system, including the Department of Health, the Department of Financial Services, and the "O" agencies such as the Office of Mental Health and the Office for People with Developmental Disabilities.[iii]

All these agencies inevitably approach issues from the parochial standpoint of their own stakeholders, as opposed to recognizing that an integrated approach is essential to effective management of the healthcare delivery system. This balkanization of responsibility not only hinders the efforts of policymakers to design policies that promote overarching goals for the healthcare delivery system, but also undermines efforts to implement integrated healthcare solutions, such as those that are necessary to better serve individuals with complex needs that cross siloed service sectors.[iv]

The topic of transparency of "health data, information, and policy analysis" is too broad to tackle in a single paper. This initial paper focuses primarily on the availability of health data, information, and policy analysis at a level that can assist providers and policymakers. Subsequent papers will address related issues that are more focused on the health data and information infrastructure necessary to optimize population health management and the integration of clinical care. Such issues include the data infrastructure required for population health management at a regional level, alternative payment methods such as value-based payments, and the pros and cons of the New York's existing organizational structure for managing the health information exchange in New York (i.e., QEs, SHIN-NY, and NYeC).

New York has been working for a number of years on enhancing various aspects of its health data infrastructure, including most notably the All Payer Database that has been in development since 2016.[v] Other efforts designed to improve the availability of useful health information (i.e., useful presentations of information based on the raw data collected) are also underway or under discussion.

As with almost any organization, the natural tendency is to seek to build a comprehensive health data, information, and policy analysis infrastructure from scratch. We are advocating that New York policymakers resist that temptation, because New York can get the infrastructure it needs much more rapidly and efficiently without trying to design a system from a blank sheet of paper.

Instead, New York should adopt as the foundation of its health data, information, and policy analysis infrastructure the model that exists today in Massachusetts through three related entities: the Center for Health Information and Analysis, the Massachusetts Health Data Consortium, and the Massachusetts Health Policy Commission. As the renowned Harvard health economist, David Cutler, who also serves as a member of the HPC Commission, says about this infrastructure:

> The data has enormous impact. We know more about the medical system in Massachusetts than any state knows about its medical care system. We have a superb, absolutely superb, data infrastructure from the Center for Health Information Analysis [and the HPC] cost trends team. We know as much as we can know about the medical system from what's happening to costs, to what's happening to measures of utilization, to what's happening to [revenue and profit] margins at different organizations, to what's happening to social determinants of health. [vi]

To borrow the phrase apocryphally attributed to Pablo Picasso, "good artists borrow and great artists steal." New York should "steal" the considerable work already done in Massachusetts to form the foundation of the health data, information, and policy analysis infrastructure in New York. Once this foundation is established, New York can customize aspects of it to meet specific policy and program objectives.

III.    **The Health Data, Information, and Policy Analysis Infrastructure in Massachusetts**

Massachusetts arguably places greater emphasis on measuring its healthcare system than any other state. Its health innovation efforts benefit greatly from its robust health data and information infrastructure, which provides more data and information for evidence-based policy making than exists in other states. [vii]

The easiest way to show the inadequacies of the health data, information, and policy analysis infrastructure in New York is to compare it to what exists in Massachusetts.

The three entities that comprise this infrastructure in Massachusetts, as identified above, are the:

- Center for Health Information and Analysis (CHIA)
- Massachusetts Health Data Consortium (MHDC), and
- Massachusetts Health Policy Commission (HPC)

The Center for Health Information and Analysis (CHIA) arguably is the most important piece of the Massachusetts infrastructure, because it collects the data and curates the information on which other parts of the infrastructure rely. Its overarching purpose is to create the factual foundation to support better healthcare policy and program management in Massachusetts.

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Non-governmental entities, such as Massachusetts Health Data Consortium (MHDC) build analytics based on the CHIA data and information. Finally, the Massachusetts Health Policy Commission (HPC) institutionalizes the process of seeking continuous improvement by providing substantial analytical resources and a framework for translating evidence based insights from health data and information into policies and program enhancements that strengthen the health care delivery system.

**Center for Health Information and Analysis**

CHIA, as an independent agency, was created in 2012 under the same statutory provision as HPC, to provide the health data and information necessary to support evidence-based program and policy decisions. CHIA has a different governance structure than that of HPC.[viii] CHIA is overseen by the Health Information and Analysis Oversight Council (the Oversight Council), which is responsible for its budget and provides guidance on research and analysis conducted by CHIA. The Oversight Council is an 11-member body that was established in the FY2016 Final Budget, and meets quarterly. CHIA is managed by an Executive Director, who is appointed by a majority vote of the Governor, Attorney General, and State Auditor. The Executive Director and Oversight Council members serve five-year terms and can be reappointed.

In contrast to New York, where multiple agencies have the authority to collect health data, CHIA has the statutory authority to collect data reports from payers and providers on a wide range of health care statistics and data. As such, CHIA serves both as the agency of record for Massachusetts health data and the primary source of health information and analytics that support program management and policy development in Massachusetts. In short, it is the primary resource in providing health information necessary for fact-based research on health related issues for the Executive, the Legislature, the Attorney General, and the State Auditor.

Although the description below endeavors to explain the health data and information available through CHIA, the best way to understand what CHIA provides is to review its website and its *Annual Report on the Performance of the Massachusetts Health Care System*. The Annual Report is a well-organized and well-written 142-page report with clear tables on the key measures of healthcare delivery in Massachusetts. The tables include not only high-level metrics, such as Total Health Care Expenditures by payer type and service category, but also curated metrics that illustrate meaningful trends within the changing healthcare environment. Appendix A to this paper, the *Information Comparison Crosswalk – Massachusetts CHIA and NY*, includes the Table of Contents of the Annual Report, which shows the comprehensive nature of health information that CHIA makes available to the public.

CHIA converts the "unrefined" health data it collects into a well curated set of health information metrics that provide a comprehensive picture of the most important aspects of the Massachusetts healthcare delivery system, including provider, payer, and population health dynamics. Data refinement is the process of transforming raw and unstructured data into clean and structured formats. The purpose of data refinement is to enhance the usability and relevance of data, so that the data can be accessed, analyzed, and interpreted by stakeholders.

Although a single statistic is easier than raw data to interpret, many more analyses and insights can be derived from raw data than can be derived from a single statistic. Because this tradeoff is

inherent, CHIA adheres to a best practice for achieving transparency by publishing the data in multiple formats that span levels of refinement including the lowest level of refinement that can be shared publicly. For each health information metric, CHIA also provides an Excel spreadsheet that includes the "unrefined" health data and "semi-refined" health information datasets, which enables further independent analysis by any interested party. The "Data" section of the website shows that CHIA organizes the data it collects into three primary buckets: the Massachusetts All Payer Claims Database; Hospital and Other Provider Data (which includes payer information); and a wide range of data categorized under Case Mix Index. The "Health Information and Analysis" refines that data information into useful metrics in the following categories: Hospital Care, Costs & Payments; Quality & Patient Safety; Access to Insurance & Use of Care; and Health System Performance.

The Case Mix section includes the Massachusetts Acute Hospital Case Mix Database is a database comprised of the Hospital Inpatient Discharge Database, Emergency Department Database and Outpatient Observation Database. For each of these databases, CHIA provides a detailed manual describing the data elements and provider-specific notes regarding potential data integrity issues.[ix]

New York collects much of this information as well, although it is much less accessible than the user-friendly format of CHIA. The difficulty of accessing this information in New York is a reflection in part of the information being held in multiple databases which are managed by different agencies who often resist making the information available to other agencies come up much less the public.[x] It is important to emphasize, however, that simply making more data publicly available would  have limited impact unless the data is organized and curated in a fashion that provides meaningful health information that frequently cuts across different silos within the health care delivery system.

The Step Two Policy Project has created a document titled: *Data Comparison Crosswalk – Massachusetts CHIA and NY* ("*Data Crosswalk")* included as Appendix B to this paper. The document is subject to change based on feedback and we are committed to updating the comparison on an ongoing basis. If the relevant New York agencies or others are able to contribute to the Crosswalk, it will be an even more complete road map for a health data and information architecture.

The Data Crosswalk shows that New York collects some, although not all, of the raw health data collected by Massachusetts, but there is a significant difference between the level of refined health information conveniently made available to the public in Massachusetts through the CHIA compared to what is available in New York in multiple data locations managed by different State agencies. As a result, it is much easier to get an overall understanding of the health care delivery system in Massachusetts than is the case in New York.

Examples of useful health information curated by CHIA include such measures as the "Payer Reported Commercial Rebates as a Percentage of Gross Pharmacy Expenditures," the "Growth in Telehealth Expenditures," and "multi-source acute hospital financial data sets" showing financial information about cost, revenue, financial performance, payer mix, utilization and other hospital characteristics. CHIA has also developed an index called the "Statewide Relative Price," which shows both price variation in the prices that providers charge consumers, as well as variation in the commercial market in the amounts that payers reimburse providers. The

issue of price variation in New York was examined in 2016 in a study partially funded by the New York State Health Foundation, and a private not-for-profit organization called Fair Health presents certain information on this issue, no governmental entity regularly tracks price variation from a consumer or provider perspective despite the major role price variation plays in access, sustainability, and affordability. [xi]

The table below summarizes some of the major categories of reporting in the CHIA Annual Report and describes ways in which CHIA utilizes this data is shown in the table below:

| CHIA Annual Report Categories | CHIA Use of Data |
|---|---|
| Provider and Health System Trends | • Analyzing healthcare spending trends |
| Behavioral Health | • Monitor healthcare system performance, including cost-containment progress |
| Quality of Care | • Conduct studies and report on the healthcare system |
| Total Medical Expenses | • Manage All-Payer Claims Database, a comprehensive source of health care claims data |
| Alternative Payment Methods | • Monitor relative financial health of hospitals and other providers |
| Private Commercial Contracts ("PCC")<br>    PCC Enrollment<br>    PCC Premiums<br>    PCC Payer Use of Funds<br>    PCC Member Cost Sharing | • Report to consumers comparative healthcare cost and quality information |

CHIA also curates and presents a useful profile of every hospital facility in Massachusetts, with key metrics in such areas as "at a glance" statistics, services, quality, utilization, patient revenue, trends, and financial performance. [xii] Appendix C shows the profile for a midsize community hospital.

The critical question, of course, is whether the existence of this greater visibility into health data and information actually benefits the healthcare delivery system. CHIA has a monthly newsletter called "Data Matters" expressly to reinforce the point that access to good health data and information does, indeed, matter. Massachusetts policymakers and outside experts (as reflected in the comment from David Cutler above) strongly believe their ability to make more evidence-based decisions because of the health and daily infrastructure improves public policy. [xiii] Conceptually, the transparency and accessibility of health data and information should enable more objective analysis and serve as a basis for well-informed policy formation and healthcare decision making.

**Massachusetts Health Data Consortium**

The Massachusetts Health Data Consortium (MHDC) was founded in 1978 to collect the kind of data now collected by CHIA to serve as a neutral third party to engage with all stakeholders on data issues. MHDC today is the non-governmental, industry-facing entity that provides analysis, data governance, health information exchange, and the convening of industry to seek to ensure that necessary changes to the health data infrastructure, especially regulatory ones, happen.

MHDC groups services into three categories: analytics, data governance (e.g., standardization and interoperability), and exchange of administrative health data. MHDC's services address the "myriad innovations in data science and analytics, data standardization and exchange, and the governance of a health data economy that puts the individual at its center."  As the MHDC website states: "The opportunities for healthcare providers and health plans to innovate and create more value for patients are rooted in sharing all health information between providers, payers, and patients. *This democratization of health data* will give patients and their caregivers the knowledge and tools to make the best choices for each patient based on each of their specific needs." (Emphasis added)

The role of MHDC in providing a comprehensive health data, information, and policy analysis infrastructure may be less central than the contributions of CHIA and HPC, but MHDC serves an important function in helping to translate the data from CHIA and the policy insights from HPC into improvements of the Massachusetts health care delivery system, as well as convening the community to implement technology and data-related initiatives. While it is less clear how the MHDC services should be translated to New York, understanding the tools it gives to providers and others should help to illuminate that question.

MHDC works closely with CHIA. MHDC does not collect any data other than from CHIA, the state of Rhode Island, and The Lown Institute, a not-for-profit health information provider that collects information from CMS and other third-party datasets to create the national Lown Institute Hospitals Index for Social Responsibility.  Instead, MHDC organizes these data into dashboards that hospitals and health systems use to support strategic planning and other analytical work.

The information dashboard maintained by MHDC is paired with an analytics tool that assists hospitals and other providers in strategic planning and benchmarking their operations compared to similar hospitals in Massachusetts. The analytics tool, called "Spotlight Analytics" Was developed in partnership with a private healthcare analytics firm. It includes comprehensive case mix and market share data from the CHIA and comprehensive equity, outcomes, and quality measures from the Lown Institute's Hospitals Index.  The Spotlight Analytics service also provides analyses of patient origin, disease prevalence, cost of care, and comparative costs and outcomes for every acute care hospital in Massachusetts and Rhode Island. With the Lown Institute data, Spotlight Analytics also provides data on how Massachusetts providers rank and compare to each other in health equity, clinical outcomes, and value of care.

The following are the types of information found on the MHDC dashboard:

| Sources of Variation | Improve & Inform |
|---|---|
| • Health services market share<br>• Geographical distributions of population and disease<br>• Utilization of clinical resources<br>• Patient outcomes<br>• Equity, value, and community benefit measures | • Care coordination within service areas<br>• Resource and services development<br>• Disparities of care/equity<br>• Population health<br>• At-risk reimbursement strategies |
| **Leveraging Lown Index Data** | |
| • Lown Institute Social Responsibility Data<br>• Market Share and Market Share Trends<br>• Patient Origin Trends<br>• Disease Volume Trends<br>• Hospital and Health System Key Performance Indicators | • Health Equity Measures<br>• Low-Value Care Measures<br>• Clinical Quality Measures<br>• Advanced Features, including saving customized reports<br>• Full export of visualizations and reports to Excel and PowerPoint |

MHDC also includes significant educational components for users of health IT. For example, MHDC worked with the Network for Excellence in Health Innovation (NEHI) to prepare a major policy analysis designed to enable Massachusetts to take a leadership role in adopting automated prior authorization solutions. Its 65-page Report was an actionable plan to standardize required activities for automated prior authorization while accounting for the Massachusetts regulatory, payer, provider, and technology environments.

**Massachusetts Health Policy Commission**

As noted above in the Executive Summary, the organizing principle of the HPC was the establishment of an annual total health expenditure growth target for Massachusetts.[xiv] The HPC is supported by a staff of 60 professionals, including data and policy analysts. According to a study by the Commonwealth Fund, "Stakeholders generally expressed respect for the expertise of HPC staff, the quality of its research, and the credibility of which helps to build consensus on the facts underlying potentially contentious policy issues."[xv] The HPC spends approximately $10 million a year on policy analysis and research staff to produce its annual report on cost trends and to conduct other deep dive analyses on a wide range of issues. Although the HPC is nominally an independent agency and is responsive to legislative input and questions, it is also closely integrated with the executive branch's health policy and budget apparatus. By statute, the equivalent of New York's Deputy Secretary for Health and the Director of the Budget are *ex officio* members of the HPC board.

HPC and CHIA share responsibility for monitoring health care spending in Massachusetts and annually measuring performance against the state's health care cost growth benchmark. For example, ahead of HPC's annual Health Care Cost Growth Benchmark Hearing, a public hearing that considers available data, information, and testimony regarding whether modification of

the [Health Care Cost Growth Benchmark](#) is appropriate, CHIA issues its [Annual Report on the Performance of the Massachusetts Health Care System.](#)  At the Benchmark hearing, CHIA staff present findings from their Annual Report, which examines trends in costs, coverage, and quality indicators to inform policymaking; and information related to provider and payer financials; and commercial insurance enrollment and premium and cost-sharing trends.

The consulting firm Mathematica conducted an in-depth review of HPC in 2022 based on interviews with 50 stakeholders. Mathematica concluded that there seems to be a general consensus that the health expenditure growth target in Massachusetts constrained overall expenditure growth over the first half of the life of HPC as payers and providers used the expenditure target as a reference point for their price negotiations.[xvi] Since then, however, the "sentinel effect" of the health expenditure growth target has diminished and health expenditure growth in Massachusetts has exceeded the target.[xvii]

In addition to compiling a comprehensive annual cost trends report and identifying opportunities for savings, the agency publishes focused analyses on specific topics such as variation in the performance of provider organizations, improving the care of patients with co-occurring disorders, and the effects of "boarding" patients with behavioral health issues in emergency departments.[xviii] Other examples of how the analytical focus of the HPC and its staff  goes beyond just reviewing healthcare expenditure growth include the full chapter in the 2022 Health Care Cost Trends Report[xix] devoted to addressing changes in ambulatory care patterns in children and adults between 2018 and the onset of the COVID-19 pandemic in 2020, "Sidebars" in the annual report examining spending on clinician-administered drugs, and reports and policy briefs on such esoteric topics as children with medically complex conditions, consolidation and closures in the pediatric health care market and certified nurse midwives and maternity care.[xx]

One reason that New York has never embraced the health policy commission idea is that a state health expenditure growth target has long been opposed by healthcare stakeholders, who believe such a target would overshadow the concerns about access and financial sustainability. We share that concern. Indeed, the primacy of concerns related to access and the financial sustainability of providers in New York would make it imperative that a permanent health policy research authority would focus on some of the same analytical issues as the HPC, but with an explicit objective of addressing not only affordability, but access and financial sustainability as well.

Because we think the underlying drivers of the issues of access, sustainability, and affordability are largely the same, we strongly believe that a permanent health policy research body in New York would develop insights to improve the overall economics of the healthcare delivery system, with efficiency gains divided among the goals of expanding access, promoting provider financial sustainability, and cost savings for health consumers. A subsequent paper will discuss in more detail how New York could create a nuanced index that takes into account all three of these related issues rather than simply focusing on health expenditure growth.

In addition to evaluating performance of the healthcare delivery system for Massachusetts as a whole, HPC uses CHIA data and information to annually review individual payer and provider spending performance. HPC has the authority to require payers and providers with excessive spending growth to implement a Performance Improvement Plan (PIP) although HPC has only

once required a health system to implement PIP to reduce spending.[xxi] As is the case with the health expenditure growth target generally, it's unlikely that New York would choose to confer this type of authority on a permanent health policy research body. But at the same time, the PIP construct and analytical approach would create a formal structure for New York 's efforts to improve the performance of financially distressed hospitals.

Much of this performance improvement  work is managed through the [Care Delivery Transformation (CDT) Committee](#) of the HPC, which is responsible for "advanc[ing] the HPC's mission to develop strategies to promote care delivery and payment system transformation…" CDT's focus areas include oversight of the HPC's certification and investment programs; learning and dissemination activities; program evaluation; expansion of alternative payment methods (APMs); quality measurement alignment and improvement; and support of related research."

According to David Seltz, the Executive Director of the HPC, one of HPC's primary objectives is to expand Medicaid health policy reforms to the commercial market. New York has found it difficult to advance this type of alignment between public and commercial payers. A permanent health policy research body with a clear mandate to take a holistic and integrated approach to improving all aspects of New York's healthcare delivery system could prove more successful than siloed regulatory agencies that inevitably seek to protect the interests of their stakeholders.

The HPC also performs other functions that are already performed by the New York State Department of Health or the Public Health Planning and Policy Commission (PHHPC) in New York. For example, the HPC analyzes consolidations within the health sector to assess whether they would lead to higher prices. The HPC also plays a quasi-regulatory role in certifying various aspects of the healthcare delivery system, such as accountable care organizations and digital health eligibility. New York would not need to burden a permanent health policy research body with these responsibilities.

Finally, a permanent health policy research entity in New York would be complementary to, and not a substitute for, a temporary Healthcare Delivery System Reform Commission of the type described Governor Hochul in the 2022 State of the State. A temporary Health Care Delivery System Reform Commission, planning for which reportedly is well underway, could focus on a strategic vision for the health care delivery system while also making recommendations for near-term tactical decisions. Such a strategic vision could identify specific areas that require long term in-depth research to operationalize the complicated restructuring of the health care delivery system.

## IV.    Conclusion And Recommendations

The development of a comprehensive health data, information, and policy research infrastructure is not a short-term fix for the challenges facing healthcare in New York. Rather, it is a legacy investment in infrastructure that is a necessary, albeit not a sufficient, condition for the effective and far-reaching restructuring of the health care delivery system in New York that will be necessary to ensure access, quality care, financial sustainability for providers and affordability for consumers.

Our specific recommendations are as follows:

1. New York should create a new governmental entity that would have overall responsibility for the collection of health data and reporting of health information at a level that is equivalent to the Massachusetts Center for Health Information and Analysis. There are significant advantages to investing in a single governmental body with the authority to collect health data from all aspects of health care delivery system in New York, including providers and payers. In the short run, however, New York could continue to have multiple agencies collect this data and have the New York health information and analysis entity synthesize that information in a data and information architecture similar to CHIA. For health data that is not currently collected in New York, but which is important to the health information and analysis infrastructure, the State should expand the collection authority of existing agencies or directly confer that authority on the New York health information and analysis entity.

2. New York should create a permanent health policy research body that engages in the types of research and analysis activities conducted by the Massachusetts Health Policy Commission. However, unlike Massachusetts, the organizing principle for a permanent health policy research body in New York should be the threefold goals of access, provider sustainability, and affordability.

3. A permanent health policy research body in New York should be complementary to, and not a substitute for, a temporary Healthcare Delivery System Reform Commission of the type described Governor Hochul in the 2022 State of the State. A temporary Health Care Delivery System Reform Commission should be helping to develop a strategic vision for the health care delivery system. Such a strategic vision inevitably will identify specific areas that require ongoing, long term and in-depth research to operationalize the complicated restructuring of the health care delivery system that such a vision is likely to require.

4. In order to avoid the balkanization of health data and information, it is essential that both the New York health information and analysis entity and the permanent health policy research body in New York are organizationally above the multiple state agencies that regulate different aspects of the healthcare delivery system in New York. There are strong advantages in making these entities public authorities in order to give them flexibility they need to rapidly scale organizations that will probably require more than 100 professionals from different disciplines. The public authority structure would also provide representation beyond the executive branch, although (consistent with other public authorities in New York) the governor would control a majority of the appointments. It is essential that these entities must become well integrated into the policy and budgetary mechanisms of the executive branch, although they would also provide information to the legislature consistent with the principle of democratization of policy analysis. Although there are significant benefits to creating these entities in the form of public authorities, if they can only be created as state agencies, they should be independent agencies with a clear mandate to supersede the authority of other state agencies as it relates to the health data, information, and policy research infrastructure.

5. New York should develop options for ensuring that services of the type offered by the Massachusetts Health Data Consortium are available to providers and policymakers in New York. New York, through the Department of Health, the Executive Chamber and the Division of

Budget, already spends considerable resources seeking to benchmark providers in New York against each other and against various best practice standards. Given the inextricably interrelated nature of the healthcare delivery system, New York should consider whether a new public or private entity should be created to more efficiently perform those functions.

**Appendix A**

*Information Comparison Crosswalk - Massachusetts CHIA and NY Version 1* (includes the Table of Contents of the CHIA 2023 Annual Report as the guide for comparison)

| Information Publicly Available via Massachusetts CHIA (2023) | Massachusetts CHIA Definitions & Data Sources | Is this Information Available Publicly in New York? Does New York Collect the Data? |
|---|---|---|
| **HEALTH CARE EXPENDITURES[i]** | | |
| **Total Health Care Expenditures (THCE)** | | **Total Health Care Expenditures (THCE)** |
| • Per Capita Total Health Care Expenditure Trends, 2013-2021<br>• Components of Total Health Care Expenditures, 2019-2021<br>• Components of Total Health Care Expenditures: Private Commercial Insurance by Product Type, 2019-2021<br>• Components of Total Health Care Expenditures: Medicare Programs, 2019-2021<br>• Components of Total Health Care Expenditures: MassHealth by Program Type, 2019-2021<br>• Components of Total Health Care Expenditures: MassHealth Enrollment by Delivery System, 2020-2021<br>• Components of Total Health Care Expenditures: Net Cost | Definition: THCE is a measure of total spending for health care in the Commonwealth. Chapter 224 of the Acts of 2012 (Chapter 224) defines THCE as the annual per capita sum of all health care expenditures in the Commonwealth from public and private sources, including: 1) all categories of medical expenses and all non-claims related payments to providers, as included in the health status adjusted total medical expenses (TME) reported by CHIA; 2) all patient cost-sharing amounts, such as deductibles and copayments; and 3) the net cost of private health insurance, or as otherwise defined in regulations promulgated by CHIA.<br><br>

| THCE CATEGORY | DATA SOURCE |
|---|---|
| **Commercially Insured Expenditures** | |
| Commercial Full-Claim | TME data reported by commercial payers to CHIA |
| Commercial Partial-Claim | TME data reported by commercial payers to CHIA with actuarial estimates |
| **Public Coverage Expenditures** | |
| MassHealth Managed Care Organizations (MCOs) and Accountable Care Organizations Model A (ACO-A) | TME data reported by commercial payers to CHIA |
| Commonwealth Care MCOs | TME data reported by commercial payers to CHIA |
| MassHealth (ACO-B, PCC, FFS, SCO, PACE, One Care, and Other) | Reported by MassHealth |
| Medicare Advantage | TME data reported by commercial payers to CHIA |
| Medicare Parts A and B | CMS data summary to CHIA |
| Standalone Medicare Part D | CMS data summary to CHIA |

| • NYS equivalent of CHIA Total Health Care Expenditures information is **not available** in NYS.<br>• Portions of the CHIA-collected data that are used to calculate the TME[1], that are **not available** in NYS include the net cost of private health insurance, non-claims related payments to providers (including provider performance payments) patient cost-sharing and Veterans Health Administration data.<br>• Given the data that is currently collected by NYS DOH APD and NYS DFS, it may be possible for NYS to provide CHIA-like information on partial NYS Health Care Expenditures |

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[1] TME is defined as the total medical spending for a member population based on allowed claims (i.e., payer paid amount plus patient cost sharing) for all categories of medical expenses and all non-claims related payments to providers. TME is expressed on a PMPM basis.

| Information Publicly Available via Massachusetts CHIA (2023) | Massachusetts CHIA Definitions & Data Sources | | Is this Information Available Publicly in New York? Does New York Collect the Data? |
|---|---|---|---|
| of Private Health Insurance by Market Sector, 2019-2021<br>• Components of Total Health Care Expenditures: Other Public Programs, 2019-2021 | Health Safety Net | Reported by HSN | that is more comprehensive than that which is currently available. |
| | Medical Security Program | Reported by commercial payers to CHIA | |
| | Veterans Health Administration | Veterans Health Administration (VA) summary data reported to CHIA for FYs 2018, 2019, and 2020 | |
| | **Net Cost of Private Health Insurance** | Calculated from the Medical Loss Ratio Reports from the Massachusetts Division of Insurance (DOI), the Annual Statutory Financial Statement and Supplemental Health Care Exhibit from the National Association of Insurance Commissioners (NAIC), and the Medical Loss Ratio Reports from the Center for Consumer Information and Insurance Oversight (CCIIO) | |
| | **Massachusetts population** | U.S. Census Bureau | |
| **Total Health Care Expenditures by Service Category** | | | **Total Health Care Expenditures by Service Category** |
| • Total Health Care Expenditures by Service Category, 2019-2021: Gross of Prescription Drug Rebates<br>• Total Health Care Expenditures by Service Category, 2019-2021: Net of Prescription Drug Rebates<br>• Change in Total Health Care Expenditures by Service Category, 2019-2021<br>• Components of Total Health Care Expenditures: | Definition: For the purposes of this report, health care expenditures by service category represent the annual sum of all THCE reported spending in each service category. Health care expenditures by service category include health care expenditures from public and private sources and consists of 1) all categories of medical payments to providers, and 2) all patient cost-sharing amounts, such as deductibles, coinsurance, and copayments. | | • NYS equivalent of CHIA Total Health Care Expenditures by Service Category information is **not available**.<br>• CHIA-collected data that is used to calculate the TME[2], that is **not available** in NYS includes the net cost of private health insurance and Veterans Health Administration data.<br>• Given the data that is currently collected by NYS |

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[2] TME is defined as the total medical spending for a member population based on allowed claims (i.e., payer paid amount plus patient cost sharing) for all categories of medical expenses and all non-claims related payments to providers. TME is expressed on a PMPM basis.

| Information Publicly Available via Massachusetts CHIA (2023) | Massachusetts CHIA Definitions & Data Sources | | Is this Information Available Publicly in New York? Does New York Collect the Data? |
|---|---|---|---|
| Commercial Spending by Service Category, 2019-2021<br>• Components of Total Health Care Expenditures: Medicare Spending by Service Category, 2019-2021<br>• Telehealth in the Commonwealth<br>• Components of Total Health Care Expenditures: Telehealth Spending | **Data Category / Data Source table** | | DOH APD and NYS DFS, it may be possible for NYS to provide CHIA-like information on partial NYS Health Care Expenditures by Service Area that is still more comprehensive than currently available. |

| Data Category | Data Source |
|---|---|
| **Commercially-Insured Pharmacy Expenditures** | |
| Commercial Full-Claim | TME data reported by commercial payers to CHIA |
| Commercial Partial-Claim | TME data reported by commercial payers to CHIA with actuarial estimates |
| **Public Coverage Pharmacy Expenditures** | |
| MassHealth MCOs and ACO-As | TME data reported by commercial payers to CHIA |
| MassHealth (FFS, PCC, Temporary, ACO-B, MCO wrap, ACO-A wrap, and supplemental payments) | Reported by MassHealth |
| Programs Primarily for Dual-Eligibles (SCO, PACE, and One Care) | Reported by MassHealth |
| Medicare Advantage | TME data reported by commercial payers to CHIA |
| Medicare Parts A and B | CMS data summary to CHIA |
| Standalone Medicare Part D | CMS data summary to CHIA |
| Health Safety Net | Reported by the HSN |
| Veterans Health Administration | Sourced from publicly available VA data |

| Prescription Drug Rebates and Pharmacy Expenditures | | | Prescription Drug Rebates and Pharmacy Expenditures |
|---|---|---|---|
| • Estimated Impact of Rebates on Pharmacy Spending and Growth, 2019-2021<br>• Range of Payer-Reported Commercial Rebates as a Percentage of Gross Pharmacy Expenditures, 2019-2021 | Definitions:<br>• Prescription Drug Rebate Share of Pharmacy Expenditures: Aggregate prescription drug rebates divided by aggregate pharmacy expenditures.<br>• Aggregate Prescription Drug Rebates: the sum of all rebates and other price concessions (including concessions from price protection and hold harmless contract clauses) provided by pharmaceutical manufacturers for prescription drugs with specified dates of fill, excluding manufacturer-provided fair market value bona fide service fees.<br>• Aggregate Pharmacy Expenditures: the sum of all incurred claim allowed payment amounts to pharmacies for prescription drugs, biological products, or | | • NYS equivalent of CHIA prescription during rebates and pharmacy expenditures information is **not available.**<br>• Rebate data for commercially insured members is **not available.**<br>• NYS DOH has drug rebate data for the Medicaid program and data for pharmacy expenditures for |

| Information Publicly Available via Massachusetts CHIA (2023) | Massachusetts CHIA Definitions & Data Sources | Is this Information Available Publicly in New York? Does New York Collect the Data? |
|---|---|---|
| | vaccines as defined by the payer's prescription drug benefit in a given calendar year, including member cost-sharing and excluding prescription drug rebates.<br>• Pharmacy Expenditures Net of Rebates: Aggregate pharmacy expenditures minus aggregate prescription drug rebates | Medicaid. NYS DFS has claims reports data for pharmacy expenditures for commercial plans.<br>• Commercial plan member cost-sharing data is **not available.** |

| Data Category | Data Source |
|---|---|
| **Rebate, Pharmacy Expenditure, and Member Month Data for Commercially-Insured Members** | |
| Commercial[13] | Data reported by commercial payers to CHIA |
| **Rebate, Pharmacy Expenditure, and Member Month Data for Publicly-Insured Members** | |
| MassHealth MCO/ACO-As | Data reported by commercial payers and MassHealth to CHIA |
| MassHealth (FFS, PCC, ACO-B, and wrap payments) | Data reported by MassHealth to CHIA |
| Medicare Advantage (Part D) | Data reported by commercial payers to CHIA |
| Medicare FFS/Medicare Prescription Drug Plans: | Data reported by commercial payers to CHIA |
| Senior Care Options (SCO) | Data reported by commercial payers to CHIA |
| One Care | Data reported by commercial payers to CHIA |
| Programs of All-Inclusive Care for the Elderly (PACE) | Data reported by commercial payers to CHIA |

| PROVIDER AND HEALTH SYSTEM TRENDS[ii] | | |
|---|---|---|
| **Hospital Utilization** | | **Hospital Utilization** |
| • Total Acute Care Hospital Inpatient Discharges, October 2018-September 2022<br>• Total Acute Care Hospital Emergency Department | • Hospital Inpatient Discharge Databases (HIDD) and Emergency Department Databases (EDD) of CHIA's Acute Hospital Case Mix Databases were used as the data sources for reporting on trends in acute hospital utilization.<br>• The HIDD and EDD are visit-level files including patient socio-demographics, diagnostic information, treatment and service information, and hospital charges. | • NYS equivalent of CHIA hospital utilization information **is available** using NYS SPARCS data. |

| Information Publicly Available via Massachusetts CHIA (2023) | Massachusetts CHIA Definitions & Data Sources | Is this Information Available Publicly in New York? Does New York Collect the Data? |
|---|---|---|
| Treat-and-Release Visits, October 2018-September 2022<br>• Acute Care Hospital Inpatient Discharges Related to COVID-19, January 2020-September 2022<br>• Acute Care Hospital Inpatient Discharges Related to COVID-19 by Expected Primary Payer Type, January 2020-September 2022<br>• Acute Care Hospital Inpatient Discharges Related to COVID-19 by Discharge Setting, January 2020-September 2022 | • For this analysis, discharge setting information reported by the facility was classified into one of six mutually exclusive categories: Home, Home with Home Health Agency Care, SNF, Rehabilitation, Expired, Other (hospice, CAH, psychiatric hospital, federal healthcare facility, another short-term general hospital for inpatient care, another type of institution not defined elsewhere, or other discharger setting.<br>• Length of Stay | |
| **Hospital and Health System Financial Performance** | | **Hospital and Health System Financial Performance** |
| • Total Margin Trends by Hospital Cohort<br>• Operating and Non-Operating Trends by Hospital Cohort<br>• Hospital Operating Revenue and Expense Trends | **Description of Financial Metrics:**<br>Financial ratio analysis is one critical component of assessing an entity's financial condition. These measures are used for hospitals and their affiliated health systems.<br>**Profitability** - This category evaluates the ability of an entity to generate a surplus.<br>    **Operating Margin**<br>       ○ Operating income is income from normal operations of an entity, including patient care and other activities, such as research, gift shops, parking, and cafeteria, minus the expenses associated with such activities. Operating Margin is a critical ratio that measures how profitable the entity is when looking at the performance of its primary activities. In HFY 2020 and HFY | • NYS equivalent of CHIA Hospital and Health System Financial Performance information is **not available** publicly in a comparable manner.<br>• NYS DOH does collect hospital Cost Report and Form 990 data, so it may be |

| Information Publicly Available via Massachusetts CHIA (2023) | Massachusetts CHIA Definitions & Data Sources | Is this Information Available Publicly in New York? Does New York Collect the Data? |
|---|---|---|
| | 2021, these margins include COVID-19 relief funding reported as operating revenue.<br><br>o Operating Margin = (Total Operating Revenue – Total Expenses Including Nonrecurring Gains or Losses) / Total Unrestricted Revenue, Gains and Other Support<br><br>**Non-Operating Margin**<br>o Non-operating income includes items that are not related to operations, such as investment income, contributions, gains from the sale of assets and other unrelated business activities.<br>o Non-Operating Margin = Total Non-Operating Revenue / Total Unrestricted Revenue, Gains and Other Support<br><br>**Total Margin**<br>o This ratio evaluates the overall profitability of the entity using both operating surplus (or loss) and non-operating surplus (or loss). In HFY 2020 and HFY 2021, these margins include COVID-19 relief funding reported as operating revenue.<br>o Total Margin = Total Excess of Revenue, Gains and Other Support Over Expenses / Total Unrestricted Revenue, Gains and Other Support<br><br>**Other Measures**<br>The following are individual line items from the Standardized Financial Filing.<br>o **Net Patient Service Revenue (NPSR):** Revenue an entity would expect to collect for services provided, including premium revenue, less contractual allowances. NPSR is the primary source of revenue for an entity.<br>o **Other Operating Revenue:** Includes revenue from services other than health care provided to patients, as well as sales and services to non-patients.<br>o **Federal COVID-19 Relief Funds**: Total funds an entity received related to the COVID-19 pandemic from federal sources that was reported as operating revenue.<br>o **State & Other COVID-19 Relief Funds**: Total funds an entity received related to the COVID-19 pandemic from state or other sources, such as private grants or contributions, that was reported as operating revenue. | possible for this information to be made available in NYS. |

| Information Publicly Available via Massachusetts CHIA (2023) | Massachusetts CHIA Definitions & Data Sources | Is this Information Available Publicly in New York? Does New York Collect the Data? |
|---|---|---|
| | ○ **Total Expenses**: Includes all expenses reported by the entity, including but not limited to salary and benefits, depreciation, interest, health safety net assessment, and other operating expenses. | |
| **Nursing Facility Utilization and Financial Performance** | | **Nursing Facility Utilization and Financial Performance** |
| • Nursing Facility Utilization, by Payer Type<br>• Nursing Facility Annual Occupancy Rates<br>• Total Facilities, Total Beds, and Median Occupancy by County, 2021<br>• Nursing Facility Median Total Margin<br>• Nursing Facility Total Revenue and Expenses | Data Source: The data underlying the metrics in the nursing facility-related slides is from the Nursing Facility Cost Reports (HCF-1 in 2019 and 2020; SNF-CR in 2021) submitted to CHIA for each calendar year 2019-2021.<br>• **Nursing Facility Utilization, by Payer Type**<br>Nursing Facility Resident Days - This metric measures the distribution of resident days by payer type: Medicaid, Medicare, Self-Pay, Commercial, other public programs, and other payer types. To compute adjusted resident days by payer type, each facility's total resident days for a given payer type within a given year were divided by the number of operating days then multiplied by the number of days in that calendar year.<br>• **Nursing Facility Annual Occupancy Rates**<br>Occupancy Rate - This metric measures the proportion of all nursing facility beds that were filled during the year.<br>• **Total Facilities, Total Operating Beds, and Occupancy by County, 2021**<br>Total Facilities, 2021 - This metric counts the number of nursing facilities which submitted a 2021 cost report to CHIA, total and in each county.<br>Total Licensed Beds, 2021 - This metric counts the number of licensed beds in nursing facilities which submitted a 2021 cost report to CHIA, total and in each county.<br>Median Occupancy Rate, 2021 - For this metric, the occupancy rate was calculated for each facility as described above, and the median value was determined, across all facilities and in each county.<br>• **Nursing Facility Median Total Margin**<br>Median Total Margin - Total margin measures the nursing facility's financial performance across all of its income and expenses. The total margin was | • NYS equivalent of CHIA Nursing Facility Utilization and Financial Performance information is **not available** publicly in a comparable manner.<br>• NYS DOH does collect nursing facility Cost Reports, so it may be possible for this information to be made available in NYS. |

| Information Publicly Available via Massachusetts CHIA (2023) | Massachusetts CHIA Definitions & Data Sources | Is this Information Available Publicly in New York? Does New York Collect the Data? |
|---|---|---|
| | calculated for each nursing facility, then the 75th percentile, median, and 25th percentile were determined across all facilities. | |
| **BEHAVIORAL HEALTH**[iii] | | |
| **Behavioral Health Expenditures** | | **Behavioral Health Expenditures** |
| • Behavioral Health Spending by Insurance Category, 2021<br>• Member Cost-Sharing as a Percentage of Total Expenditures by Insurance Category, 2021<br>• Range of Payer-Reported Substance Use Disorder Expenditures as a Percentage of Total Behavioral Health Expenditures by Insurance Category, 2021<br>• Commercial Behavioral Health Expenditures Per Member Per Month for Pediatric and Non-Pediatric Physician Groups, 2021 | Definitions: The following definitions are applicable to the Behavioral Health chapter of CHIA's Annual Report only.<br>• Behavioral Health Expenditures: Includes incurred claims (payer-paid), member-cost-sharing, and non-claims-based payments for services that met CHIA's criteria for behavioral health services, including general services provided by a behavioral health clinician, and behavioral health services provided by any practitioner.<br>• Total Health Expenditures: Total medical and prescription drug spending for services that were not classified as behavioral health.<br>• Member Months (annual): The number of members participating in a plan over the specified period of time expressed in months of membership.<br>• BH Member Months (annual): The number of members participating in a plan over the specified period of time expressed in member months, who had a Behavioral Health principal diagnosis at any point during the reporting year.<br>• Member Cost-Sharing: Total member cost-sharing/member paid amounts for service category spending.<br>• Substance Use Disorder Expenditures: Includes incurred claims (payer-paid), member-cost-sharing, and non-claims-based payments for services that met CHIA's criteria for substance use disorder services in accordance with the SUD service subset code list.<br>• Pediatric Provider Group Behavioral Health Expenditures: Expenditures classified as behavioral health for members attributed to a provider organization in which at least 75% of its patients are children up to the age of 18. | • NYS equivalent of CHIA Behavioral Health Expenditures information is **not available**.<br>• Commercial member-cost sharing data and total medical and prescription drug spending is **not available**.<br>• NYS DOH does collect Article 28 Hospital Inpatient Cost Transparency data which combines SPARCS and Institutional Cost Reports and NYS OMH collects Medicaid utilization and expenditures as well as the Mental Health Inpatient Use for General Hospitals, Private Hospitals, State Psychiatric Centers, and Residential Treatment Facilities, so it may be possible for some of this |

| Information Publicly Available via Massachusetts CHIA (2023) | Massachusetts CHIA Definitions & Data Sources | Is this Information Available Publicly in New York? Does New York Collect the Data? |
|---|---|---|
| | • Non-Pediatric Provider Group Behavioral Health Expenditures: Expenditures classified as behavioral health for members attributed to a provider organization which does not meet the criteria of a pediatric provider group defined. | information to be made available in NYS. |
| **Behavioral Health Acute Hospital Utilization** | | **Behavioral Health Acute Hospital Utilization** |
| • Total Acute Care Hospital Inpatient Discharges with Behavioral Health Primary Diagnosis, October 2018-September 2022<br>• Total Emergency Department Treat-and-Release Visits with Behavioral Health Primary Diagnosis, October 2018-September 2022<br>• Acute Care Hospital Inpatient Discharges with a Behavioral Health Primary<br>• Diagnosis by Condition Category among Patients Aged 2-17, FFY 2021<br>• Acute Care Hospital Inpatient Discharges with a Behavioral Health Primary<br>• Diagnosis by Condition Category among Patients Aged 18-64, FFY 2021 | <u>Overview</u><br>• For this report, the Hospital Inpatient Discharge Databases (HIDD) and Emergency Department Databases (EDD) of CHIA's Acute Hospital Case Mix Databases (see above) were used as the data source for reporting on behavioral health utilization in acute hospitals.<br>• The HIDD and EDD are visit-level files including patient socio-demographics, diagnostic information, treatment and service information, and hospital charges.<br>• They include only discharges or visits at acute hospitals and <u>do not</u> include data from private psychiatric hospitals, substance abuse facilities, or Department of Mental Health hospitals.<br><u>Behavioral Health</u><br>• Inpatient discharges and treat-and-release ED visits were categorized into clinical meaningful independent behavioral health categories based on the listed primary and secondary diagnosis codes using the Clinical Classifications Software Refined (CCSR) for ICD-10-CM diagnoses.<br>• The CCSR for ICD-10-CM diagnoses was developed by the Agency for Healthcare Research and Quality (AHRQ) and aggregates over 70,000 ICD-10-CM diagnosis codes into over 530 clinically meaningful categories, organized across 21 body systems. This report uses CCSR v. 2023.1. | • NYS equivalent of CHIA Behavioral Health Acute Hospital Utilization information **is available** using NYS SPARCS data. |

| Information Publicly Available via Massachusetts CHIA (2023) | Massachusetts CHIA Definitions & Data Sources | Is this Information Available Publicly in New York? Does New York Collect the Data? |
|---|---|---|
| • Acute Care Hospital Inpatient Discharges with a Behavioral Health Primary<br>• Diagnosis by Condition Category among Patients Aged 65+, FFY 2021<br>• | | |
| **Behavioral Health Hospital Statistics and Outpatient Visits** | | **Behavioral Health Hospital Statistics and Outpatient Visits** |
| • Outpatient Behavioral Health Utilization<br>• Massachusetts Hospital Statistics, HFY 2021 | Outpatient Visits:<br>The total outpatient visits reported by the hospital.<br>Description of Metrics:<br>Licensed Beds<br>• The average number of beds during the fiscal year that were licensed for patient use.<br>Staffed Beds<br>• The average number of beds during the fiscal year that were in service and staffed for patient use.<br>Percent Occupancy<br>• The average percent of staffed inpatient beds occupied during the reporting period.<br>• Percent Occupancy = (Inpatient Days) / (Weighted Average Staffed Beds * Number of Days in Reporting Period)<br>Average Length of Stay<br>• The average duration of an inpatient admission.<br>Average Length of Stay = Inpatient Days / Discharges. | • NYS equivalent of CHIA Behavioral Health Hospital Statistics and Outpatient Visits is **not available**.<br>• NYS OMH Outpatient Capacity in the County Planning Profiles **is available**.<br>• NYS OMH collects ad hoc data related to Hospital Statistics. |
| **QUALITY OF CARE IN THE COMMONWEALTH**[iv] | | |

| Information Publicly Available via Massachusetts CHIA (2023) | Massachusetts CHIA Definitions & Data Sources | Is this Information Available Publicly in New York? Does New York Collect the Data? |
|---|---|---|
| **Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)** | | **Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)** |
| • Patient-Reported Experience During Acute Hospital Admission, CY 2021 | Data Source: CMS Hospital Compare; all payers, ages 19+<br>Definition: All HCAHPS scores were retrieved from CMS Hospital Compare as pre-calculated percentages. Where a hospital's performance is not included in Hospital Compare because of small numbers, missing data, or because the measure does not apply, the measure is also not included in the report. | • NYS hospital information **is available** on the CMS.gov Hospital CAHPS website |
| **Consumer Assessment of Healthcare Providers & Systems Clinician and Group Patient Centered Medical Home Survey (CG CAHPS, 4.0 (beta) Survey) – Primary Care (Adult and Pediatrics)** | | **Consumer Assessment of Healthcare Providers & Systems Clinician and Group Patient Centered Medical Home Survey (CG CAHPS, 4.0 (beta) Survey) – Primary Care (Adult and Pediatrics)** |
| • Primary Care Patient-Reported Experiences for Adults, 2018, 2020 and 2021<br>• Primary Care Patient-Reported Experiences for Pediatrics, 2018, 2020 and 2021<br>• MassHealth Member Primary Care Patient-Reported Experiences for Adults, 2019-2021<br>• MassHealth Member Primary Care Patient-Reported Experiences for Pediatrics, 2019-2021 | Data Source: Massachusetts Health Quality Partners, Patient Experience Survey (PES); commercially insured members of five plans in Massachusetts, in an HMO, PPO, or POS health plan product, MassHealth, pediatric patients ages 0-17, adult patients ages 18+. | • NYS Medicaid Satisfaction Survey Report - NYS **is available** through a member experience survey conducted every other year for adults enrolled in Medicaid managed care plans. The Department uses the results from this survey to determine variation in member satisfaction among plans.<br>• Patient Centered Medical Home Satisfaction with the Experience of Care (2013) – |

| Information Publicly Available via Massachusetts CHIA (2023) | Massachusetts CHIA Definitions & Data Sources | Is this Information Available Publicly in New York? Does New York Collect the Data? |
|---|---|---|
| | | Adult and Child CAHPS PCMH **is available.** <br>• eQARR - An Online Report on Quality Performance Results for Health Plans in New York State (includes a "Satisfaction with Care" Domain) **is available**. <br>• New York State Department of Health Managed Long-Term Care 2021 Member Satisfaction Survey Summary Report **is available**. |
| **Readmissions** | | **Readmissions** |
| • Trends in Statewide All-Payer Adult Acute Hospital Readmission Rate, Discharges, and Readmissions, SFY 2011-2021 <br>• Discharge Diagnoses with the Highest Number of Readmissions, 2021 <br>• Quarterly Trends in All-Payer Discharges, Readmissions, and Readmission Rate by COVID-19 Status, April 2020-June 2021 | Definition: CHIA has adapted the Hospital-Wide All-Cause Unplanned 30-day Readmission Measure (NQF #1789) developed by CMS and the Yale Center for Outcomes Research and Evaluation to report on all-payer readmissions in the Commonwealth. The measure was applied to CHIA's Hospital Inpatient Discharge Database, which is collected from all non-federal acute care hospitals in Massachusetts. This year's report uses the 2022 CMS readmission measure methodology (version 11.0), which uses the V24 CMS-HCC crosswalk and updates the planned readmissions algorithm. Some discontinuity in trends may be attributable to the change in diagnostic coding from ICD-9-CM to ICD-10-CM. Readmission is defined as an inpatient admission to an acute care facility in Massachusetts occurring within 30 days of an eligible index discharge. Analyses include eligible discharges for adults aged 18 and older with any payer, excluding discharges for obstetric or primary psychiatric care. All readmissions are counted except for those that are considered planned. | • Statewide all-payer potentially preventable readmission rates by hospital data **is available** via Health Data NY. <br>• Statewide all-payer potentially preventable emergency visit rates by patient county and patient zip code **is available** via Health Data NY. <br>• COVID-19-specific data **is available** on Health Data NY. |

| Information Publicly Available via Massachusetts CHIA (2023) | Massachusetts CHIA Definitions & Data Sources | Is this Information Available Publicly in New York? Does New York Collect the Data? |
|---|---|---|
| **The Leapfrog Group** | | **The Leapfrog Group** |
| • Rates of Maternity-Related Procedures Relative to Performance Targets, by Hospital, 2021<br>• Hospital Adherence to the Leapfrog Standard for Safe Practices and Hand Hygiene, 2021 | Data Source: The Leapfrog Group Hospital Survey; all payers, all ages.<br>Definition: Quality performance data were received from The Leapfrog Group as pre-calculated scores, including comparisons to standards defined by The Leapfrog Group. Participation in the Leapfrog Hospital survey is voluntary; where a hospital does not complete the survey or report on certain items in the survey, the data for that entity is also not included in the report. | • NYS hospital-specific information **is available** on the Leapfrog Ratings webpage. |
| **TOTAL MEDICAL EXPENSES & ALTERNATE PAYMENT METHODS**ᵛ | | |
| **Total Medical Expenses (TME)** | | **Total Medical Expenses (TME)** |
| • Change in Commercial HSA TME by Payer, 2019-2021<br>• Change in Commercial Unadjusted TME by Payer, 2019-2021<br>• Change in MassHealth MCO and ACO-A HSA TME by Payer, 2019-2021<br>• Change in MassHealth MCO and ACO-A Unadjusted TME by Payer, 2019-2021<br>• Change in Aggregate HSA Scores by Commercial and MassHealth MCO/ACO-A by Payer, 2019-2021 | Data Source:<br>Collected annually by CHIA from both commercial and public payers.<br>Definitions: TME is defined as the total medical spending for a member population based on allowed claims (i.e., payer paid amount plus patient cost sharing) for all categories of medical expenses and all non-claims related payments to providers. TME is expressed on a PMPM basis.<br>• Member zip code TME measures the total health care spending of each Massachusetts zip code, based on member residence, rather than where members received services. TME can be measured on an unadjusted basis, which reflects actual spending but does not consider differences among member populations. TME may also be adjusted to reflect differences in member demographics and health status such as age, gender, and clinical profile. This report presents both unadjusted and health-status adjusted (H.S.A.) TME data.<br>• Unadjusted TME is the actual payments from a commercial payer and its members to health care providers. Unadjusted TME is presented for aggregated analyses | • **Not available** in NYS as NYS does not collect the full amount paid to providers, including both payments from health plans and member cost-sharing payments. NYS does not collect all non- claims related payments to providers, such as provider performance payments. |

| Information Publicly Available via Massachusetts CHIA (2023) | Massachusetts CHIA Definitions & Data Sources | Is this Information Available Publicly in New York? Does New York Collect the Data? |
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| | across payers, such as statewide and regional analyses. Unadjusted TME is used for such purposes since payers in these analyses utilized different methods in adjusting for health status, and H.S.A. TME results calculated from different health status adjustment methods cannot be directly compared.<br>• Health-Status Adjusted TME is the total health care spending for the member population of a payer's membership based on allowed claims for all categories of medical expenses and all non-claims related payments to health care providers, adjusted by health status, and expressed on a PMPM basis. H.S.A. TME is analyzed in order to examine the payer-specific TME growth rate for their member populations. This ensures that each payer's TME accounts for the health status and resource utilization of their member populations when comparing a payer's TME growth rate to the health care cost growth benchmark.<br>• Health-Status Adjustment score is a value that measures a member's illness burden and predicted resource use based on differences in member characteristics or other risk factors.<br>• Commercial full-claims data includes both self- and fully-insured commercial business for which claims for all medical services were available to the reporting payer. The data captures complete medical spending and is used to calculate commercial TME.<br>• Commercial partial-claims data includes self- and fully-insured commercial business where the employer separately contracts for one or more specialized services, such as pharmacy or behavioral health service management. In these cases, the reporting payer does not have access to the claims for the separately contracted services. As the full range of medical expenses is not included in the data reported by the payers, these partial-claims are not included in the TME analyses contained in this report. | |

| Information Publicly Available via Massachusetts CHIA (2023) | Massachusetts CHIA Definitions & Data Sources | Is this Information Available Publicly in New York? Does New York Collect the Data? |
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| **Managing Physician Group TME** | | **Managing Physician Group TME** |
| • Change in Managing Physician Group Commercial HSA TME, 2019-2021<br>• Change in Managing Physician Group Commercial Unadjusted TME for BCBSMA, HPHC, and THP Networks Combined, 2019-2021 | Data Source:<br>Collected annually by CHIA from both commercial and public payers.<br>Definition:<br>Managing physician group TME measures the total health care spending of members whose plans require the selection of a primary care physician associated with a physician group, adjusted for health status. Thus, managing physician group TME reported by each payer contains exclusively managed care member information. The data reported for each physician group include TME for these members, even when care was provided outside of the physician group. Data related to pediatric physician groups were excluded from the physician group TME analyses | |
| **Alternative Payment Methods (APM)** | | **Alternative Payment Methods (APM)** |
| • Adoption of Alternative Payment Methods by Insurance Category, 2019-2021 | Definition:<br>APMs are payment methods used by a payer to reimburse heath care providers that are not solely based on the fee-for-service (FFS) basis. In some APM contracts, financial risk associated with both the occurrence of medical conditions as well as the management of those conditions is shifted from payers to providers to incentivize efficiency and quality of health care delivery.<br>Data Source:<br>CHIA collects data on APM from the ten largest commercial payers in the Massachusetts commercial health insurance market, and commercial payers that offered Medicare Advantage plans and MassHealth MCO/ACO-A plans.<br>Definitions:<br>• Global Payment: Global payments are a type of payment arrangement between payers and providers that establishes a spending target for a comprehensive set of health care services to be delivered to a specified population during a defined time period. Global payment arrangements may shift some financial risk from payers to providers. In these cases, if costs exceed the budgeted amounts, | • NYS equivalent of CHIA Adoption of Alternative Payment Methods by Insurance Category is **not available**<br>• NYS DOH has some information on Medicaid Value Based Payment models.  Information on commercial payment models is not collected by NYS. |

| Information Publicly Available via Massachusetts CHIA (2023) | Massachusetts CHIA Definitions & Data Sources | Is this Information Available Publicly in New York? Does New York Collect the Data? |
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| | providers must absorb those costs, subject to negotiated risk sharing agreements. On the other hand, providers may share in, or retain, the savings if costs are lower than the budgeted amounts and health care quality performance targets are met. It is important to note that within the framework of a global payment arrangement with a managing physician group, payments to service providers are generally made on a FFS basis. Also, global payments as defined here do not consider the extent of risk, if any, borne by the managing physician group. It is difficult to capture levels of risk, as there is currently no standardized approach to risk classification or reporting.<br><br>• Limited Budget: Limited budgets, like global payments, represent a move away from FFS-based payments. Limited budgets are payment arrangements whereby payers and providers, either prospectively or retrospectively, agree to pay for a specific set of services to be delivered by a single provider. This could include, for instance, capitated primary care or oncology services. Limited budgets also shift some financial risk from payers to providers.<br><br>• Bundled Payment: Bundled payments are a method of reimbursing providers, or a group of providers, for providing multiple health care services associated with defined "episodes of care" (e.g., knee surgery, pregnancy and delivery, and etc.) for a patient or set of patients. These payments may include services developed based upon clinical guidelines, severity adjustments to account for the general health status of a patient and comorbidities (other related ailments), and even designated "profit" margins and allowances for potential complications.<br><br>• Other, non-FFS-based: This category includes all other payment arrangements that are not based on a FFS model, but that also do not easily fit into any of the other categories. This category includes supplemental payments for the Patient Center Medical Home Initiative (PCHMI), for instance.<br><br>• Fee-for-service (FFS): Under this model, health care providers are reimbursed by payers at negotiated rates for individual services delivered to patients. A variety of FFS payment arrangements exist, including, but not limited to, Diagnosis Related Groups (DRGs), per-diem payments, claim-based payments adjusted by | |

| Information Publicly Available via Massachusetts CHIA (2023) | Massachusetts CHIA Definitions & Data Sources | Is this Information Available Publicly in New York? Does New York Collect the Data? |
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| | performance measures, and discounted charge-based payments. This category also includes pay-for-performance incentives that accompany FFS payments. | |
| **PRIVATE COMMERCIAL CONTRACT ENROLLMENT**[vi] | | |
| • Enrollment by Market Sector, 2019-2021<br>• Enrollment by Product Type, 2019-2021<br>• Enrollment by Market Sector and Product Type, 2021<br>• Enrollment by Funding Type, 2021<br>• Largest Payers by Market Sector, 2021<br>• Enrollment Changes by Payer, 2020-2021<br>• Enrollment by Benefit Design, 2019-2021<br>• High Deductible Health Plan (HDHP) Enrollment by Market Sector, 2019-2021 | Payer data was provided in response to the "2022 Annual Premiums Data Request," which was developed with the assistance of Gorman Actuarial, Inc.<br>• This request included detailed definitions and specifications for membership, premiums, claims, and other cost data.<br>• It specified that payers provide data on their primary, medical, private commercial membership for all group sizes, including the individual and small group segments of the merged market.<br>• Products that were specifically excluded from this report were: Medicare Advantage, Medicaid, Medicare supplement, Federal Employees Health Benefits Program, and non-medical (e.g., dental) lines of business. | • CHIA-like Private Commercial Enrollment information is **not available** in NYS.<br>• Medicaid Program Enrollment by Month, Medicaid Managed Care Enrollment Reports, Managed Care Reports, Essential Plan and QHP Enrollment data, and Child Health Plus Enrollment **is available**. |
| **PRIVATE COMMERCIAL PREMIUMS**[vii] | | |
| • Private Commercial Premiums and COVID-19<br>• Fully-Insured Premiums by Market Sector, 2019-2021<br>• Fully-Insured Benefit Levels by Market Sector, 2021 | Payer-reported data from the "2022 Annual Premiums Data Request" enabled CHIA to report on commercial premiums, benefit levels, member cost-sharing, and allowed and incurred claims.<br>• Benefit Levels<br>• Fully-Insured Premiums<br>• Medical Loss Ratio (MLR) rebate amounts | CHIA-like Private Commercial Premium Information is **not available** in NYS. |

| Information Publicly Available via Massachusetts CHIA (2023) | Massachusetts CHIA Definitions & Data Sources | Is this Information Available Publicly in New York? Does New York Collect the Data? |
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| • Fully-Insured Premiums by Payer, 2019-2021<br>• ConnectorCare Premiums and Market Share, 2019-2021<br>• Unsubsidized Individual Premiums and Market Share, 2019-2021 | • Allowed and Incurred Claims<br>• Member Cost-Sharing | |
| **PRIVATE COMMERCIAL PAYER USE OF FUNDS**[viii] | | |
| • Fully-Insured Payer Use of Premiums by Market Segment, 2019-2021<br>• Understanding the Differences: Federal Medical Loss Ratio and CHIA's Annual Financial Loss Ratio<br>• Fully-Insured Non-Medical Expenses and Surplus by Market Segment, 2019-2021<br>• Fully-Insured Non-Medical Expense Components and Surplus by Market Segment, 2019-2021 | How payers used the premium revenue that they collected from their commercial fully-insured lines of business for 2019-2021. CHIA analyzed financial data from payer-submitted Massachusetts Division of Insurance's Medical Loss Ratio Reporting Forms and CCIIO Medical Loss Ratio Reporting Forms.<br>• Non-Medical Expenses and Surplus - CHIA's Annual Financial Loss Ratio formula, which represents the percentage of premiums spent on members' medical costs, was developed in accordance with actuarial principles and methods for the purpose of measuring how much of an insurer's premium was retained in a given year. CHIA's Annual Financial Loss Ratio differs from the federal MLR formula and cannot be used to determine whether MLR thresholds were met. Any MLR rebates paid for each reporting year were subtracted from the premiums for that year. Incurred claims were adjusted for pharmacy rebates, CSR subsidy payments, and risk adjustment and high-cost risk pool payments.<br>• Non-Medical Expense Components and Surplus - Non-medical expense components shown in the report can be further decomposed to the categories detailed below. These categories are based on aggregations of MLR Reporting Form line items for the 2019-2021 reporting years. Any excess premium funds not allocated by payers to non-medical expenses are reported by CHIA as surplus (net gains). | |

| Information Publicly Available via Massachusetts CHIA (2023) | Massachusetts CHIA Definitions & Data Sources | Is this Information Available Publicly in New York? Does New York Collect the Data? |
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| **PRIVATE COMMERCIAL MEMBER COST-SHARING**[ix] | | |
| • Cost-Sharing by Market Sector, 2019-2021<br>• Cost-Sharing in Context, 2019-2021<br>• Cost-Sharing by Deductible Level, 2019-2021<br>• Enrollment by Deductible and Maximum Out-of-Pocket Level, 2019-2021<br>• Private Commercial Insurance Affordability, 2019-2021 | Average cost-sharing PMPM was calculated by subtracting incurred claims amounts and CSR subsidy amounts, if applicable, from allowed claims amounts and dividing by annual member months.<br>Payers also reported enrollment based on members' deductible and out-of-pocket spending limits. CHIA provided deductible and out-of-pocket maximum ranges for member month reporting. To enable comparisons across plans, payers were instructed to report based on individual (single) policy amounts, even for members enrolled in family policies with higher limits. | • Cost sharing information in NYS is only available for plans offered on the NYSOH.<br>• NYS does not collect cost sharing information for commercial plans not on the NYSOH |

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[i] THCE, TME, APM Technical Appendix https://www.chiamass.gov/assets/2023-annual-report/2023-Annual-Report-Technical-Appendices.zip

[ii] Provider and Health System Trends Technical Appendix https://www.chiamass.gov/assets/2023-annual-report/2023-Annual-Report-Technical-Appendices.zip

[iii] Behavioral Health Technical Appendix https://www.chiamass.gov/assets/2023-annual-report/2023-Annual-Report-Technical-Appendices.zip

[iv] Quality of Care Technical Appendix https://www.chiamass.gov/assets/2023-annual-report/2023-Annual-Report-Technical-Appendices.zip

[v] THCE, TME, APM Technical Appendix https://www.chiamass.gov/assets/2023-annual-report/2023-Annual-Report-Technical-Appendices.zip

[vi] Enrollment Premiums, Member Cost-Sharing, Payer Use of Funds Technical Appendix https://www.chiamass.gov/assets/2023-annual-report/2023-Annual-Report-Technical-Appendices.zip

[vii] Ibid

[viii] Ibid

[ix] ibid

**Appendix B**

*Data Comparison Crosswalk - Massachusetts CHIA and NY Version 1*

## Data Collected by Massachusetts CHIA

The Center for Health Information and Analysis (CHIA) is an independent state agency whose mission is to serve as a steward of Massachusetts health information to promote a more transparent and equitable health care system that effectively serves all residents of the Commonwealth

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| Hospital User Agreement | In addition to the data sources below, there are other data streams CHIA collects that support public reporting on quality, access, coverage, and affordability: |
| Other Providers User Agreement | Aggregate collection from health plans of provider organization-level results of selected HEDIS measures |
| Nursing Facility User Agreement (PDF) | Massachusetts Health Insurance Survey |
| Non-Confidential Data Security Agreement (PDF) | Massachusetts Employer Survey |
| User Agreement for Insurance Carriers | Massachusetts Healthcare Workforce Survey |

## Data Collected in NYS  (closest equivalent)

APD Regulation

APD Guidance Manual

| Payer Data | | | Payer Data | | NYS_IDs |
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| All-Payer Claims Database | The MA APCD is a database comprised of: medical, pharmacy, and dental claims, as well as information about member eligibility, providers, and insurance coverage. **The MA APCD promotes transparency and affords a deeper understanding of the Massachusetts health care system by providing health care providers, health plans, and academicians a consistent source of care patterns analyses and statewide metrics for cost, quality, and access. Health plans, researchers, and others use the MA APCD to analyze and report on population health management, quality outcomes, costs and pricing variations.** Learn more - https://www.chiamass.gov/ma-apcd/ | Requires a data request. Currently Available: MA APCD Calendar Year 2021 (2017-2021 data with six-month run out from 2022). CHIA extracts data from the APCD Release Data Mart to create extract files for its customers. It can take from five to seven days to create an extract file. CHIA prioritizes delivery of extracts to Commonwealth agencies doing research in support of healthcare policy. Second priority is given to organizations that submit data. Third priority goes to independent researchers. | NYS All Payer Database | The All Payer Database (APD) was created to provide policymakers, researchers, and consumers with a comprehensive, health-focused, data warehousing and analytic solution for New York State.  Through a Master Patient Index, Master Provider Index, and a suite of data enrichment tools, the APD warehouse and analytic solution seeks to consolidate previously siloed data sources and fill gaps in the types of information available to support DOH's mission. The All-Payer Database contains data from varying sources including health plan enrollment data (Commercial, ERISA, Qualifed Health Plans, Medicaid, Child Health Plus and Medicare FFS), claims and encounter data, provider data, hospital discharge data, vital statistics mortality data and Provider Network Data System (PNDS) and other provider data.<br><br>The APD's public-facing website, the NYS Health Connector - https://nyshc.health.ny.gov/web/nyapd/home, launched on May 16, 2018 provides multiple data dashboards as a resource for consumers, researchers, and the general public. Information provided includes:   Health Plan Quality Ratings Dashboards; flu and measles trackers; volume and estimated cost of Cardiac surgery, joint replacement, spinal and bariatric surgery, and birth at hospitals across NYS; high-level summaries of how often people visit the ED, what kinds of conditions they are seeking treatment for, and how the number of ED visits differs across counties statewide. The dashboard also includes calculations that estimate whether an ED visit for certain conditions could have been avoided with adequate access to care, care coordination, or patient monitoring. | 1 |
| Premiums Data | **CHIA reports on changes over time in Massachusetts health insurance premiums, benefit levels, member cost-sharing, and product design.** CHIA collects annual commercial health insurance premiums data from health care payers, allowing for insights into the costs borne by both Massachusetts employers and employees. CHIA also monitors high deductible health plan enrollment and consumer cost-sharing over time. | Premiums data is reported annually to CHIA by health plans and published as part of CHIA's Annual Report. More information on the Premiums data specifications can be found here: https://www.chiamass.gov/payer-data-reporting-premiums-data/, and results can be found here: https://www.chiamass.gov/annual-report/. | NYSOH Compare Plans and Estimate Cost | Individuals seeking health coverage through NYS' health marketplace can find information on health insurance options available to individuals and families,  allows for a comparison of  health plan options and supports application for assistance that could lower the cost of health coverage. Individuals and families can also see if they qualify for free or low-cost coverage from Medicaid, Child Health Plus, or the Essential Plan through the Marketplace. | 2 |
| | | | NYS DFS Individual and Small Group Medical Premium Rates | The Department of Financial Services publishes an annual update on health plan requested rate increases by plan.  Information that is available publicly includes: Benefit Year, Summary of Requested Rate Actions, Resquested & Approved Rate Actions - Additional Information, Consumer Comments, Final Exhibits, Lowest Cost Approved Rates (Excel). | 3 |
| | | | NYS DFS Premium Rate Actions Final Exhibits | The Department of Financial Services publishes an annual update on health plan requested rate increases by plan.  Information that is available publicly includes: Benefit Year, Summary of Requested Rate Actions, Resquested & Approved Rate Actions - Additional Information, Consumer Comments, Final Exhibits, Lowest Cost Approved Rates (Excel). | 4 |
| | | | Health Insurance Premiums on Policies Written in New York Annually | The Department of Financial Services' produces an annual report on individiaul health plan assets, liabilities and premiums written.  This information is used to create a summary chart included within the Annual Report to the Governor and Legislature and is available publicly on Data.ny.gov | 5 |

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| **Primary and Behavioral Health Care Expenditures** | Primary care and behavioral health care (PCBH) comprise an array of vital services that can meaningfully shape patient outcomes and are often associated with lower health care costs and higher quality. However, comprehensive data on expenditures for these services in Massachusetts has been limited. To build **a foundational dataset that can support future policy initiatives and provide insight into the Commonwealth's investment in these areas, CHIA collected data on payments made by commercial health plans to health care providers delivering primary care and behavioral health services. CHIA monitors costs, cost trends, price, quality, utilization, and patient outcomes related to behavioral health service subcategories**. Behavioral health service subcategories include, but are not limited to: mental health, substance use disorder, outpatient, inpatient, services for children, services for adults, and provider types as defined in statute. | Available publicly on the CHIA website - https://www.chiamass.gov/primary-care-and-behavioral-health-care-pcbh-expenditures/ - Primary Care and Behavioraial Health Care Expenditures: Baseline Report (pdf), interactive expenditures dashboard (Tableau), and databook (Excel). | **NYS Office of Mental Health County Planning Profiles** | This tool allows the public to view and interact with the NYS OMH county level data. Part I: Medicaid Utilization - this part displays Medicaid utilization and expenditure data for the Medicaid eligible public mental health population in NYS from 2014 forward. This population is consistent with the federal definition of the public mental health system prior to the NYS Medicaid system redesign. The reports include Medicaid fee-for-service (FFS) and Medicaid managed care encounters in the service utilization and expenditures reported for the selected population. Part II: Mental Health Inpatient Use - the Mental Health Inpatient Use report displays average daily inpatient census and population rates of utilization by region and county of residence for psychiatric inpatient settings in NYS, including: General Hospitals, Private Hospitals, State Psychiatric Centers and Residential Treatment Facilities. Part III: Mental Health Outpatient and Housing Program Capacity - The Mental Health Outpatient and Housing Program capacity report displays Housing, Outpatient service and clinic capacities for regions and counties of provider across NYS. Clinics are broken out by data sources; Medicad for Medicaid claims, PCS for non-Medicaid estimates, and <ental Health Automated Recorded system (MHARS) for State Psychiatric Centers services. Part IV: Psychiatric Inpatient Readmissions - The Psychiatric Readmission report displays the rates of readmission to psychiatric inpatient facilities and to EMergency Room settings for psychiatric reasons within 30 and 90 days of discharge from a Psychiatric Inpatient facility. The data are displayed by Region and County and includes qualifies discharges from MH licensed General Hospitals, Private Hospitals, and State Psychiatric Centers across NYS. | 6 |
| | | | **Hospital Inpatient Cost Transparency: Beginning 2009** | This dataset contains information submitted by New York State Article 28 Hospitals as part of the New York Statewide Planning and Research Cooperative (SPARCS) and Institutional Cost Report (ICR) data submissions. The file contains information on the volume of discharges, All Payer Refined Diagnosis Related Group (APR-DRG), the severity of illness level (SOI), medical or surgical classification the median charge, median cost, average charge and average cost per discharge. DOES NOT INCLUDE data from Article 31 psychiatric hospitals or NYS-Operated Psychiatric Centers. | 7 |
| | | | **QARR: Access to Primary Care by Payer** | The column chart shows rates of access to primary care for managed care plans by payer. The chart can be filtered by measurement year or measure by changing these options under the Filter tab. The chart uses statewide average rates of all insurance plans. Removing the statewide average filter is not recommended. For more information, check out http://www.health.ny.gov/health_care/managed_care/reports/quality_performance_improvement.htm. The "About" tab contains additional details concerning this dataset. | 8 |
| | | | **QARR: Medicaid Access to Primary Care by Year: Beginning 2008** | The column chart shows rates of access to primary care for Medicaid managed care by year. The chart can be filtered by measure by changing the option under the Filter tab. The chart uses statewide average rates of all insurance plans. Removing the statewide average filter is not recommended. For more information, check out http://www.health.ny.gov/health_care/managed_care/reports/quality_performance_improvement.htm. The "About" tab contains additional details concerning this dataset. | 9 |
| | | | **Patient Centered Medical Home Quarterly Reports** | New York State Patient Centered Medical Homes Quarterly Report details the number of PCMH recognized providers by region and practice size and number of enrollees assigned to providers and details Medical Home Spending by MMC Product Line. | 10 |
| **Total Medical Expenses and Alternative Payment Methods Data** | CHIA monitors health care spending by public and private payers in Massachusetts using three key metrics: Total Health Care Expenditures (THCE), Total Medical Expenses (TME), Alternative Payment Methods (APMs). These measures are all reported in CHIA's Annual Report on the Performance of the Massachusetts Health Care System. THCE compares actual health care cost growth with the growth benchmark set by the Health Policy Commission. This measure of total health care spending in the Commonwealth includes: All categories of medical expenses paid to providers, All non-claims-related payments to providers, such as performance payments, Member cost-sharing payments to providers, such as deductibles, co-payments, and co-insurance, The net cost of private health insurance. TME represents the full amount paid to providers for health care services delivered to a payer's member population, expressed on a per member per month (PMPM) basis. TME includes the amounts paid by the payer and patient cost-sharing, and covers all categories of medical expenses and all non-claims related payments to providers, including provider performance payments. APMs are methods of payment used by health care payers to reimburse health care providers not solely based on a fee-for-service (FFS) basis. APMs shift payer-provider insurance contracts away from the traditional fee-for-service model toward a value-based payment system. The most common APMs in Massachusetts are global budgets, which establish spending targets for a comprehensive set of health care services to be delivered to a specified population. | Available publicly on the CHIA Website - https://www.chiamass.gov/thce-tme-apm - Key Annual Report THCE Metric (jpg), Key Annual Report TME Data (jpg), Key Annual Report APM Data (jpg), measures are all reported in all reported in CHIA's Annual Report on the Performance of the Massachusetts Health Care System - https://www.chiamass.gov/annual-report/. The Annual Report includes technical appendicies (pdf) and databooks (Excel). | **NYS Department of Financial Services Health Care Claims Reports** | Insurance Law section 345 requires insurers and HMOs (issuers) to submit reports to the Superintendent quarterly and annually on health care claims payment performance for comprehensive health insurance coverage. The reports provide information on claims received, claims paid, and claims denied and their dollar values, by major category of health care provider. The reports are due to the Superintendent 45 days after the end of the reporting period. | 11 |

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| | | | NYS All Payer Database | The All Payer Database (APD) was created to provide policymakers, researchers, and consumers with a comprehensive, health-focused, data warehousing and analytic solution for New York State.  Through a Master Patient Index, Master Provider Index, and a suite of data enrichment tools, the APD warehouse and analytic solution seeks to consolidate previously siloed data sources and fill gaps in the types of information available to support DOH's mission. The All-Payer Database contains data from varying sources including health plan enrollment data (Commercial, ERISA, Qualifed Health Plans, Medicaid, Child Health Plus and Medicare FFS), claims and encounter data, provider data, hospital discharge data, vital statistics mortality data and Provider Network Data System (PNDS) and other provider data. | 12 |
| | | | Medicaid Global Spending Cap Updates | Quarterly Global Cap Report (pdf) | 13 |
| | | | Value Based Payment (VBP) | This webpage provides an overview of relevant information related to NYS's VBP efforts. | 14 |
| Relative Price Data | CHIA reports annually on relative price to examine provider price variation in Massachusetts. **Relative Price (RP) facilitates comparison of average provider prices while accounting for differences in patient acuity, the types of services providers deliver to patients, and the different insurance product types (e.g., HMO, PPO) that payers offer to their members**. | Available publicly on the CHIA Website - https://www.chiamass.gov/relative-price-and-provider-price-variation/ - Executive Summary (pdf), interactive dashboard (Tableau), Technical Appendix (pdf), Methodology Report (pdf), databook (Excel). | NYHealthcare Compare - coming soon | Not yet available.  2020 SOTS proposal to "enable consumers to more easily search for health care services, Governor Cuomo will direct the Department of Health, the Department of Financial Services, and the New York State Digital and Media Services Center to create a consumer-friendly website, called NYHealthcareCompare, where New Yorkers will easily be able to find health care costs and quality information. This will empower New Yorkers to become educated consumers of health care services and choose the health care facility that fits their needs. Additionally, the platform will provide consumers with educational resources designed to help consumers know their rights including financial assistance options, what to do about a surprise bill, and more (p. 266)."  Legislation has also been introduced that would require the state to release an annual report that discloses hospital prices, differences and comparisons. https://www.nysenate.gov/legislation/bills/2023/S4097/amendment/A | 15 |
| | | | Volume and Estimated Cost of Hospital Services | NYS Health Connector -  This dashboard shows the number of times surgeries and procedures were performed and the estimated costs at hospitals across New York State. The estimated facility costs show that the cost for these procedures may vary between hospitals. There are many reasons for variation in estimated cost, including how complex your situation is (severity), overall number of procedures performed, location, or the type of medical care provided. The amount a private insurer pays a hospital or the amount that an individual consumer would pay may be different than the costs shown on this dashboard. The goal of this dashboard is to support consumers in understanding that variation occurs, and that discussing differences in cost and volume for these procedures with a medical professional can help consumers make informed health care decisions. | 16 |
| | | | Fair Health | FAIRHEALTH is an independent, national nonprofit organization that provides fair and neutral information  about healthcare costs based on claims  information submitted by  health insurers.  This information is used to estimate what providers charge, and what insurers pay, for providing healthcare to patients all across the country. This information is made available to consumers, researchers, businesses and others. | 17 |
| Prescription Drug Rebate Data | **CHIA considers the effect of drug rebates and other price concessions in the aggregate** without disclosure of any product or manufacturer-specific rebate or price concession information, and without limiting or otherwise affecting the confidential or proprietary nature of any rebate or price when detailing cost growth trends in its Annual Report. | Pharmacy is included as a Service Category in CHIA's publicly available Annual Report on the Performance of the Massachusetts Health Care System - https://www.chiamass.gov/annual-report/. The Annual Report includes technical appendicies (pdf) and databooks (Excel). | Medicaid Global Spending Cap Updates | Medicaid Quarterly Global Cap Reports include some information related to pharmacy and rebates. | 18 |

## Hospital Data

| Dataset | Description | Access Notes |
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| Acute Hospital Case Mix Data | The Massachusetts Acute Hospital Case Mix Database is a database comprised of: inpatient, outpatient and emergency dept data. Acute Hospital Case Mix data includes case specific, diagnostic discharge data that describe socio-demographic characteristics of the patient, the medical reason for the admission, treatment and services provided, the duration and status of the stay in the hospital, and the full, undiscounted total and service-specific charges billed by the hospital. **Government agencies, healthcare providers, payers, and researchers use CHIA's Case Mix databases for a wide variety of projects, including: public health initiatives, preventable hospitalizations, hospital market analysis, alternative care settings, and comparative costs and outcomes in acute care hospitals.** Examples include: The **Mass. Department of Public Health** has used Case Mix data to support a variety of its programmatic and research efforts: *The Health and Disability Program* identified a cohort of individuals with disabilities to track for hospitalizations over time as part of its mission to promote the health and wellbeing of people with disabilities in Massachusetts. *The Occupational Health Surveillance Program* monitors Case Mix files to identify potential cases with work-related health conditions and work-related injuries. The *Bureau of Health Statistics* links Case Mix data to birth certificate data and health plan data to examine the completeness and quality of responses on data sets as well as to develop performance measures. The *Bureau of Family and Community Health* identifies maternal morbidities, pregnancy associated mortalities in their Maternal Mortality and Morbidity Reviews. The *Bureau of Substance Abuse Services* analyzes treatment needs and gaps in services. **Mass. Health Data Consortium and several analytic firms** have developed a reporting product that hospitals use for planning and benchmarking. Additionally, all of the *academic medical centers* in Massachusetts, as well as the surrounding states, request Case Mix data directly for service area planning, benchmarking, and population health management. **Harvard University Kennedy School of Government** studied trends in health care utilization before and after health reform efforts, and evaluated whether expanded coverage increased demand for medical care and made access to care more difficult. | Requires a data request. Case Mix Overview https://www.chiamass.gov/case-mix-data/ |
| Behavioral Health Facilities Case Mix Data | CHIA collects behavioral health facility data from participating providers on patient demographics, diagnoses and procedures, physicians, and charges for each inpatient discharge in Massachusetts. | These data are included in the Annual Report on the Performance of the Massachusetts Health Care System and in additional reports that measure mental health and substance use disorders across specific settings and populations. |
| Electronic Health Record Data (EHRD) | CHIA collects hospital data on patient demographics, diagnoses and procedures, physicians, and charges for each inpatient discharge, outpatient observation stay, and emergency department visit in Massachusetts. This data will be shared with MassHealth in an Enhanced Demographics Data File in support of the MassHealth health equity program. | These data are used in population health analyses. |
| Hospital Charge Book Data | CHIA collects hospital charge book data from acute and non-acute hospitals. These reports are used by CHIA for **regulatory, policy development, monitoring and informational purposes.** | These data may be available via a public record request. |
| Hospital Cost Reports | CHIA collects annual hospital cost report for both acute care and non-acute care hospitals. The Massachusetts Hospital Cost Report leverages data already reported by hospitals to Medicare on the CMS 2552-10 filing, while still collecting data specific to Massachusetts hospitals. **This report is used by CHIA for regulatory, policy development, monitoring and informational purposes.** The Hospital Cost Report Data Access Tool allows users to query CHIA's hospital cost report data base and provides the opportunity to create customized requests containing cost, revenue, payer mix, and utilization data from Massachusetts acute and non-acute hospitals. | To access the data, you will need a username and password; prospective users need to register for this information and will immediately receive a user name and password. |

## Hospital Data

| Dataset | Description | # |
|---|---|---|
| All Payer Hospital Inpatient Discharges by Facility (SPARCS De-Identified) | The Statewide Planning and Research Cooperative System (SPARCS) is a comprehensive data reporting system which collects patient level detail on patient characteristics, diagnoses, treatments, services, and charges for every hospital discharge from an Article 28 facility; ambulatory surgery discharges from hospital-based ambulatory surgery centers and all other facilities providing ambulatory surgery services; and emergency department visits in New York State. This dataset is a summary of the SPARCS inpatient discharge data. | 19 |
| Hospital Inpatient Cost Transparency: Beginning 2009 | This dataset contains information submitted by New York State Article 28 Hospitals as part of the New York Statewide Planning and Research Cooperative (SPARCS) and Institutional Cost Report (ICR) data submissions. The file contains information on the volume of discharges, All Payer Refined Diagnosis Related Group (APR-DRG), the severity of illness level (SOI), medical or surgical classification the median charge, median cost, average charge and average cost per discharge. DOES NOT INCLUDE data from Article 31 psychiatric hospitals or NYS-Operated Psychiatric Centers. | 20 |
| NYS Office of Mental Health County Planning Profiles | Dashboard (Tableau) that includes: Medicaid Utilization, Mental Health Inpatient Use, Mental Health Outpatient and Housing Program Capacity, and Psychiatric Inpatient Readmissions. | 21 |
| SPARCS | SPARCS is a comprehensive all payer data reporting system established in 1979 as a result of cooperation between the healthcare industry and government. The system was initially created to collect information on discharges from hospitals. SPARCS currently collects patient-level detail on patient characteristics, diagnoses and treatments, services, and charges for each hospital inpatient stay and outpatient (ambulatory surgery, emergency department, and outpatient services) visit; and each ambulatory surgery and outpatient services visit to a hospital extension clinic and diagnostic and treatment center licensed to provide ambulatory surgery services. | 22 |
| Inpatient Cost Transparency | This dataset contains information submitted by New York State Article 28 Hospitals as part of the New York Statewide Planning and Research Cooperative (SPARCS) and Institutional Cost Report (ICR) data submissions. The file contains information on the volume of discharges, All Payer Refined Diagnosis Related Group (APR-DRG), the severity of illness level (SOI), medical or surgical classification the median charge, median cost, average charge and average cost per discharge. The Institutional Cost Report (ICR) is a uniform report completed by New York hospitals to report income, expenses, assets, liabilities, and statistics to the Department of Health (DOH). Under DOH regulations, (Part 86-1.2), Article 28 hospitals are required to file financial and statistical data with DOH annually. | 23 |
| Hospital Cost Report Audited Data Print Image: 2019 | This print image version of the Institutional Cost Report (ICR) has been audited by the DOH. is the Institutional Cost Report (ICR) is a uniform report completed by New York hospitals to report income, expenses, assets, liabilities, and statistics to the Department of Health (DOH). Under DOH regulations, (Part 86-1.2), Article 28 hospitals are required to file financial and statistical data with DOH annually. The data filed is part of the ICR and is received electronically through a secured network. This data is used to develop Medicaid rates, assist in the formulation of reimbursement methodologies, and analyze trends. For more information, check out: http://www.health.ny.gov/facilities/hospital/index.htm. | 24 |

| | | | | | # |
|---|---|---|---|---|---|
| | | | Hospital Cost Report Audited Data: 2019 | This version of the Institutional Cost Report (ICR) has been audited by a Certified Public Accounting Firm. The ICR is a uniform report completed by New York State hospitals to report income, expenses, assets, liabilities, and statistics to the Department of Health (DOH). Under DOH regulations, (Part 86-1.2), Article 28 hospitals are required to file financial and statistical data with DOH annually. The data filed is part of the ICR and is received electronically through a secured network. This data is used to develop Medicaid rates, assist in the formulation of reimbursement methodologies, and analyze trends. For more information, check out: http://www.health.ny.gov/facilities/hospital/index.htm | 25 |
| Hospital and Hospital Health System Financial Performance Data | CHIA collects annual and quarterly financial reports from hospital health systems, acute hospitals, and their affiliated physician organizations. CHIA uses this information for financial monitoring and also publishes this information in annual and quarterly industry publications, as well as in individual online hospital fact sheets and databooks. | Available publicly Massachusetts Hospital Profiles - https://www.chiamass.gov/hospital-profiles/ - that contain financial health metrics and quality metrics for individual hospitals. This includes financial information for each of the multi-acute hospital systems in the Commonwealth. Executive Summary (pdf), Profiles (pdf), interactive dashboard (Tableau), databook (excel), technical appendix (pdf), Profiles compendium (pdf). | Hospital Provider Cost Report - CMS.gov | Medicare-certified institutional providers are required to submit annual cost reports. The cost report contains provider information such as facility characteristics, utilization data, cost and charges by cost center (in total and for Medicare), Medicare settlement data, and financial statement data. CMS maintains the cost report data in the Healthcare Provider Cost Reporting Information System (HCRIS). Filtering the dataset by "NY" provides cost report data for NY hospital providers that is publicly available and downloadable. | 26 |
| Top Ten Highest Compensated Employees Report | CHIA collects employee compensation reports annually from acute hospitals. The Top Ten Highest Compensated Employees Report will be used by CHIA for regulatory, policy development, and informational purposes. | | Employee compensation reports | No similar requirement nor report issued officially by NYS. Numerous independent entities collect this information and report publicly, e.g. ProPublica - https://projects.propublica.org/nonprofits/states/NY | 27 |
| | | | IRS Form 990 | Online search tool or download specific data sets.<br><br>Tax Exempt Organization Search Tool:<br>Form 990 Series Returns<br>Form 990-N (e-Postcard)<br>Pub. 78 Data<br>Automatic Revocation of Exemption List<br>Determination Letters<br>Tax Exempt Organization Search Bulk Data Downloads<br>You can download the latest data sets of information about tax-exempt organizations:<br>Pub. 78 Data<br>Automatic Revocation of Exemption List<br>Form 990-N (e-Postcard)<br>Form 990 Series | 28 |
| **Provider Cost Reports** | | | **Provider Cost Reports** | | |
| Adult Day Health Cost Reports | CHIA collects Adult Day Health (ADH) Cost Reports on an annual basis. CHIA and other public entities use these reports for monitoring costs and for health care payment policy development. | Available via a public record request. | Adult Day Health Cost Reports | Not publicly available. | 29 |
| Adult Foster Care Cost Reports | The reports are used by CHIA and other public entities for monitoring costs and for health care payment policy development. | Available via a public record request. | Adult Foster Care Cost Reports | Not publicly available. | 30 |
| Ambulance Cost Reports | CHIA collects Ambulance and Wheelchair Van Cost Report from ambulance and wheelchair van providers. The reports are used by CHIA and other public entities for monitoring costs and for health care payment policy development. | Available via a public record request. | Ambulance Cost Reports | Not publicly available. | 31 |
| Community Health Center Cost Reports | The reports are used by CHIA and other public entities to monitor costs and to develop health care payment policy. | Available via a public record request. | CMS Healthcare Cost Report Information System (HCRIS) Dataset - Freestanding Federally Qualified Health Center | Available from CMS.gov - The dataset is normally updated quarterly and is available on the last day of the month following the quarter's end.<br>This cost report dataset can be loaded into Microsoft Excel, however, most of our data users are loading the data into Microsoft Access, Oracle, SAS, SPSS Statistical Package, Microsoft SQL Server, and DB2. | 32 |
| Group Adult Foster Care Cost Reports | The reports are used by CHIA and other public entities for monitoring costs and for health care payment policy development. | Available via a public record request. | Group Adult Foster Care Reports | | 33 |
| Nursing Facility Cost Reports | The reports are used by CHIA and other public entities for monitoring costs and for health care payment policy development. | Available publicly via Tableau file - https://www.chiamass.gov/long-term-care-facility-cost-reports/#nursing-homes . Contains the cost reports for all Massachusetts resident care facilities that submitted cost reports in 2020. You can sort by column or scrolling to the name of the facility. You can also search by combinations of name, address, city/town and/or ZIP code within the search boxes on the right. | Nursing Home Cost Report (RHCF): 2021 | The Nursing Home Cost Report (RHCF) is a uniform report completed by New York nursing homes to report income, expenses, assets, liabilities, and statistics to the Department of Health (DOH). Under DOH regulations (Part 86-2.2), nursing homes are required to file financial and statistical data with DOH annually. The data filed is part of the cost report and is received electronically through a secured network. This data is used to develop Medicaid rates, assist in the formulation of reimbursement methodologies, and analyze trends. | 34 |
| Nursing Services Cost Reports | CHIA and other public entities use these reports to monitor costs and to develop health care payment rates. | Available via a public record request. | Nursing Services Cost Reports | | 35 |
| Resident Care Facility Cost Reports | These reports are used by CHIA and other public entities for monitoring costs and for health care payment policy development. | Available publicly via Tableau file - https://www.chiamass.gov/long-term-care-facility-cost-reports/#rest-homes . Contains the cost reports for all Massachusetts resident care facilities that submitted cost reports in 2020. You can sort by column or scrolling to the name of the facility. You can also search by combinations of name, address, city/town and/or ZIP code within the search boxes on the right. | Nursing Home Cost Report | The Nursing Home Cost Report (RHCF) is a uniform report completed by New York nursing homes to report income, expenses, assets, liabilities, and statistics to the Department of Health (DOH). Under DOH regulations (Part 86-2.2), nursing homes are required to file financial and statistical data with DOH annually. The data filed is part of the cost report and is received electronically through a secured network. This data is used to develop Medicaid rates, assist in the formulation of reimbursement methodologies, and analyze trends. | 36 |

## Insurance and Coverage Data

| Enrollment Data | For this reporting, coverage is defined by unique Massachusetts residents with primary, medical membership in the 12 largest commercial payers, MassHealth (Medicaid), or Medicare. Enrollment measures are also reported in CHIA's Annual Report on the Performance of the Massachusetts Health Care System. | CHIA's bi-annual Enrollment Trends reporting includes an interactive dashboard, a detailed databook, and technical appendix - https://www.chiamass.gov/enrollment-in-health-insurance/. |
|---|---|---|
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## Insurance and Coverage Data

| Medicaid Program Enrollment by Month | This dataset aggregates and displays the number of New York State Medicaid enrollees by eligibility year and month within each NYS Economic Region, health insurance plan information, and enrollee demographics.  Enrollment in commercial health plans | 37 |
|---|---|---|
| Medicaid Managed Care Enrollment Reports | Includes Medicaid Managed Care, NYSOH, MLTC, Medicaid Advantage Plus, FIDA-IDD, and HARP | 38 |
| Managed Care Reports | Reports on health plan performance designed to help individuals choose a health plan that meets their needs.   The reports provide easy-to-read information on health plan performance with respect to primary and preventive health care, access to health care, behavioral health and enrollee satisfaction. Data is provided for commercial and government-sponsored managed care. Enrollment reports show the level of consumer participation in various types of managed care plans. | 39 |
| NYSOH - Essential Plan and QHP Enrollment Data | Coverage data for individuals enrolled in Medicaid, Child Health Plus (CHPlus), and the Essential Plan (EP) | 40 |
| Child Health Plus Program Enrollment: Beginning 2009 | This dataset contains the aggregate number of Child Health Plus Beneficiaries by eligibility year and month within each economic region, health plan, gender, age group, and race/ethnicity. Child Health Plus is a government insurance program for eligible children through the month in which they turn nineteen, whose income and resources fall within program guidelines. | 41 |
| Child Health Plus Program Enrollment by County and Insurer: Beginning 2009 | The Child Health Plus enrollment and demographic data show the aggregate number of Child Health Plus Beneficiaries by eligibility year and month within each county and health plan.<br>Child Health Plus is a government insurance program for eligible children through the month in which they turn nineteen, whose income and resources fall within program guidelines. | 42 |

| NYS_IDs | Data Source | Topic | Data Provider | Format | Lowest Level of Refinement | Accessibility | Update Frequency | Timeliness | Smallest Granularity | Geographic Scope |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | NYS All Payer Database | Payer Data | NYSDOH | Database | Raw data | Public but requires data request | Daily | Real time | Claims, Vital events | New York State |
| 2 | NYSOH Compare Plans and Estimate Cost | Payer Data | NYSDOH | Web application | | Public without data request requirement | Annually | | Health Plan | New York State |
| 3 | NYS DFS Individual and Small Group Medical Premium Rates | Payer Data | NYSDFS | Other | Aggregated line-list data | Public without data request requirement | | | Individual Health Insurance Plans | New York State |
| 4 | NYS DFS Premium Rate Actions Final Exhibits | Insurance and Coverage Data | NYSDFS | Database | Aggregated line-list data | Public without data request requirement | Annually | Months lag | | New York State |
| 5 | Health Insurance Premiums on Policies Written in New York Annually | Payer Data | NYSDFS | Dataset | Aggregated line-list data | Public without data request requirement | Annually | Months lag | Individual company | New York State |
| 6 | NYS Office of Mental Health County Planning Profiles | Payer Data, Hospital Data | NYSOMH | Dashboard | Dashboard | Public without data request requirement | Annually | Years lag | County-level counts and rates | New York State |
| 7 | Hospital Inpatient Cost Transparency: Beginning 2009 | Hospital Data | NYSDOH | Dataset | Aggregated line-list data | Public without data request requirement | Annually | Years lag | Hospital All Payer Refined Diagnosis Related Group | New York State |
| 8 | QARR: Access to Primary Care by Payer | Payer Data | NYSDOH | Dataset | Aggregated line-list data | Public without data request requirement | Annually | Years lag | Health Plan | New York State |
| 9 | QARR: Medicaid Access to Primary Care by Year: Beginning 2008 | Payer Data | NYSDOH | Dataset | Aggregated line-list data | Public without data request requirement | Annually | Years lag | Health Plan | New York State |
| 10 | Patient Centered Medical Home Quarterly Reports | Provider Data | NYSDOH | PDF report | Static report | Public without data request requirement | Quarterly | Years lag | Provider Recognition Level/Region of the State | New York State |
| 11 | NYS Department of Financial Services Health Care Claims Reports | Payer Data | NYSDFS | Dataset | Aggregated line-list data | Public without data request requirement | Quarterly | Months lag | Health Care Claims Payment Performance by Individual | New York State |
| 13 | Medicaid Global Spending Cap Updates | Payer Data | NYSDOH | PDF report | Static report | Public without data request requirement | Quarterly | Months lag | State | New York State |
| 14 | Value Based Payment (VBP) | Payer Data | NYSDOH | Web application | Static report | Public without data request requirement | As needed | Months lag | Health Plan | New York State |
| 15 | NYHealthcare Compare - coming soon | Payer Data | | | | | | | | |
| 16 | Volume and Estimated Cost of Hospital Services | Payer Data | NYSDOH | Dashboard | Dashboard | Public without data request requirement | As needed | Years lag | Individual Facilities, by procedure category and year | New York State |
| 17 | Fair Health | Insurance and Coverage Data | FAIR Health | Web application | Dashboard | Public without data request requirement | Real time | Real time | Individual Procedure Costs | United States |
| 19 | All Payer Hospital Inpatient Discharges by Facility (SPARCS De-Identified) | Hospital Data | NYSDOH | Dataset | Aggregated line-list data | Public without data request requirement | Annually | Years lag | Number of Discharges | New York State |
| 22 | SPARCS | Hospital Data | NYSDOH | Database | Raw data | Public but requires data request | Monthly | Months lag | Individual Claims | New York State |
| 23 | Inpatient Cost Transparency | Hospital Data | NYSDOH | Dataset | Aggregated line-list data | Public without data request requirement | Annually | Years lag | Hospital All Payer Refined Diagnosis Related Group | New York State |
| 24 | Hospital Cost Report Audited Data Print Image: 2019 | Hospital Data | NYSDOH | Image | Raw data | Public without data request requirement | Annually | Years lag | Facility | New York State |
| 25 | Hospital Cost Report Audited Data: 2019 | Hospital Data | NYSDOH | Database | Raw data | Public without data request requirement | Annually | Years lag | Facility | New York State |
| 26 | Hospital Provider Cost Report - CMS.gov | Hospital Data | CMS | Database | Raw data | Public without data request requirement | Real time | Years lag | Facility | United States |
| 27 | Employee compensation reports | Hospital Data | | | | | | | | |
| 28 | IRS Form 990 | Hospital Data | IRS | Database | Raw data | Public without data request requirement | Real time | Years lag | Individual Non-Profit Organizations | United States |
| 29 | Adult Day Health Cost Reports | Provider Cost Reports | NYSDOH | Database | Aggregated line-list data | Public without data request requirement | Annually | Years lag | Facility | |
| 30 | Adult Foster Care Cost Reports | Provider Cost Reports | | | | Not available for sharing | | | | |
| 31 | Ambulance Cost Reports | Provider Cost Reports | | | | Not available for sharing | | | | |
| 32 | CMS Healthcare Cost Report Information System (HCRIS) Dataset - Freestanding Federally Qualified Health Center | Provider Cost Reports | CMS/FQHCs | Database | Aggregated line-list data | Public without data request requirement | Quarterly | Months lag | Freestanding Federally Qualified Health Center provider | United States |
| 33 | Group Adult Foster Care Reports | Provider Cost Reports | | | | | | | | |
| 34 | Nursing Home Cost Report (RHCF): 2021 | Provider Cost Reports | NYSDOH | Database | Raw data | Public without data request requirement | Annually | Years lag | Facility | New York State |
| 35 | Nursing Services Cost Reports | Provider Cost Reports | | | | | | | | |
| 37 | Medicaid Program Enrollment by Month | Insurance and Coverage Data | NYSDOH | Dataset | Aggregated line-list data | Public without data request requirement | Monthly | Months lag | Medicaid Enrollment Data | New York State |
| 38 | Medicaid Managed Care Enrollment Reports | Insurance and Coverage Data | NYSDOH | Database | Aggregated line-list data | Public without data request requirement | Monthly | Weeks lag | Medicaid Enrollment Data | New York State |
| 39 | Managed Care Reports | Insurance and Coverage Data | NYSDOH | PDF report | Static report | Public without data request requirement | Annually | Years lag | Health Plan | New York State |
| 40 | NYSOH - Essential Plan and QHP Enrollment Data | Insurance and Coverage Data | NYSDOH | PDF report | Aggregated line-list data | Public without data request requirement | Monthly | Weeks lag | Enrollment by County | New York State |
| 41 | Child Health Plus Program Enrollment: Beginning 2009 | Insurance and Coverage Data | NYSDOH | Dataset | Aggregated line-list data | Public without data request requirement | Monthly | Weeks lag | Economic Region | New York State |
| 42 | Child Health Plus Program Enrollment by County and Insurer: Beginning 2009 | Insurance and Coverage Data | NYSDOH | Dataset | Aggregated line-list data | Public without data request requirement | Monthly | Weeks lag | County | New York State |
| #N/A | NYS Health Connector | Insurance and Coverage Data | NYSDOH | Web application | Dashboard | Public without data request requirement | Annually | Years lag | Health Plan | New York State |
| #N/A | Value Based Payment Roadmap | Payer Data | NYSDOH | PDF report | Static report | Public without data request requirement | As needed | Years lag | State | New York State |
| #N/A | NYS Adult Care Facility Profiles | Provider Cost Reports | NYSDOH | Web application | Raw data | Public without data request requirement | Quarterly | Months lag | Individual Facilities | New York State |
| #N/A | Voluntary Foster Care Agencies Rates | Provider Cost Reports | NYSOCFS | PDF report | Static report | Public without data request requirement | Semiannually | Months lag | Individual Agencies | New York State |
| #N/A | NYSOH Premium & Out-of-Pocket Cost Estimator | Insurance and Coverage Data | NYSDOH | Web application | Dashboard | Public without data request requirement | Annually | Real time | Individual Health Plan Premium and Cost Estimates | New York State |

| Term | Definition |
|---|---|
| *Data Source* | The name or identifier of the healthcare data source. |
| *Topic* | The main focus or subject matter of the data source. |
| *Data Provider* | The entity or organization responsible for collecting, managing, and distributing the data. |
| *Format* | The way in which the data are structured or presented (e.g., raw data, aggregated line-list data, dashboard, static report, other). |
| *Level of Refinement* | The format that reflects the degree of processing applied to raw data to make it more accessible and meaningful for analysis and decision-making (e.g., raw data, aggregated line-list data, dashboard, static report). |
| *Accesssibility* | How easily the data can be obtained (e.g., open, requires data request, not public). |
| *Update Frequency* | How often the data source is refreshed or updated with new information (e.g., real-time, daily, weekly, monthly, quarterly, annually, as needed, other). |
| *Timeliness* | How quickly the data become available after the occurrence of the events they represent (e.g., real time, days lag, weeks lag, months lag, years lag). Timeliness describes the lag between real-world events and the inclusion of those events in the data source. |
| *Granularity* | The level of detail or specificity present in the data. Granularity describes the extent to which individual data points are broken down, such as whether it provides aggregate statistics or detailed, individual-level information. In a structured table of rows and columns, for example, the granularity is the unit represented by each of the table's rows. |
| *Scope* | The geographical, temporal, or demographic coverage of the data source. |

**Appendix C**

# Anna Jaques Hospital
## 2021 Hospital Profile

### OVERVIEW

| | | | |
|---|---|---|---|
| City/Town: | Newburyport, MA | Tax Status: | Non-profit |
| Region: | Northeastern Massachusetts | Trauma Center Designation: | Adult: Level 3 |
| Hospital Type: | Community Hospital | Total FTE's in HFY21: | 692.56 |
| Total Staffed Beds in HFY21: | 140, Mid-Size Hospital | FY21 Case Mix Index: | 0.90 |
| Hospital System Affiliation: | Beth Israel Lahey Health | Public Payer Mix[2]: | 61.7% |
| Hospital System Surplus (Deficit) in HFY21: | $352,045,000 | Percent of Total GPSR - Medicare/Medicaid/Commercial: | 51% / 10% / 34% |
| Change in Ownership HFY17-HFY21: | Beth Israel Lahey Health 3/1/19 | CY20 Commercial Statewide Relative Price: | 0.76 |

### FINANCIAL

#### GROSS AND NET PATIENT SERVICE REVENUES (GPSR & NPSR)

| | HFY17 | HFY18 | HFY19 | HFY20 | HFY21 |
|---|---|---|---|---|---|
| Inpatient GPSR | $71.8M | $73.9M | $79.1M | $70.3M | $73.9M |
| Outpatient GPSR | $189.2M | $196.3M | $215.0M | $182.8M | $219.8M |
| Total GPSR | $261.0M | $270.2M | $294.1M | $253.1M | $293.7M |
| Inpatient NPSR per CMAD | $8,404 | $8,316 | $8,283 | $8,789 | $8,939 |
| Inpatient NPSR | $47.1M | $48.0M | $48.1M | $45.5M | $48.7M |
| Outpatient NPSR | $76.9M | $80.9M | $85.0M | $69.6M | $82.8M |

#### REVENUE & EXPENSES

| | HFY17 | HFY18 | HFY19 | HFY20 | HFY21 |
|---|---|---|---|---|---|
| Operating Revenue | $129.1M | $133.8M | $78.7M | $126.3M | $141.2M |
| Non-Operating Revenue[4] | $1.7M | $0.4M | $7.3M | $0.8M | $3.8M |
| COVID Funding Included in Operating Revenue[5] | - | - | - | $6.6M | $4.9M |
| Total Revenue | $130.8M | $134.1M | $86.0M | $127.2M | $145.0M |
| Total Expenses | $128.7M | $132.4M | $79.5M | $133.6M | $143.0M |
| Total Surplus (Deficit) | $2.2M | $1.8M | $6.5M | ($6.4M) | $1.9M |
| Operating Margin | 0.4% | 1.0% | (0.9%) | (5.7%) | (1.3%) |
| Non-Operating Margin | 1.3% | 0.3% | 8.5% | 0.6% | 2.6% |
| Total Margin | 1.7% | 1.3% | 7.5% | (5.0%) | 1.3% |

#### SOLVENCY AND LIQUIDITY

| | HFY17 | HFY18 | HFY19 | HFY20 | HFY21 |
|---|---|---|---|---|---|
| Total Net Assets or Equity | $25.5M | $33.5M | $21.0M | $8.7M | $26.6M |
| Current Ratio | 2.5 | 2.1 | 3.5 | 1.6 | 1.6 |
| Debt Service Coverage Ratio | 4.0 | 3.7 | 5.7 | (0.1) | 4.4 |
| Cash Flow to Total Debt | 19.6% | 17.9% | 28.2% | (1.2%) | 12.1% |
| Equity Financing Ratio | 28.7% | 38.1% | 22.7% | 8.3% | 23.1% |
| Average Age of Plant | 19.0 | 20.0 | 0 | 0 | 3.0 |

### UTILIZATION

| | |
|---|---|
| Licensed Beds in HFY21: | 140 |
| Available Beds in HFY21: | 140 |
| Staffed Beds in HFY21: | 140 |
| HFY21 Percentage Occupancy: | 57.5% |
| Inpatient Discharges in HFY21: | 6,030 |
| Change HFY20-HFY21: | (1.9%) |
| Percent of Total Region Discharges in HFY21: | 4.6% |
| Percent of Statewide Total Discharges in HFY21: | <1% |
| Inpatient Days in HFY21: | 29,390 |
| Change HFY20-HFY21: | 6.1% |
| Percent of Total Region Inpatient Days in HFY21: | 4.7% |
| Percent of Statewide Total Inpatient Days in HFY21: | <1% |
| Average Length of Stay in HFY21: | 4.87 |
| Change HFY20-HFY21: | 8.0% |
| Emergency Department Visits in HFY21: | 22,519 |
| Change HFY20-HFY21: | 1.3% |
| Percent of Total Region Emergency Department Visits in HFY21: | 4.6% |
| Percent of Statewide Total Emergency Department Visits in HFY21: | <1% |
| Outpatient Visits in HFY21: | 60,836 |
| Change HFY20-HFY21: | 5.1% |

#### TOP DISCHARGES BY INPATIENT CASE (DRG) IN FY21

| Inpatient Case (DRG)[6] | Discharges | Percent of Total Hospital Discharges |
|---|---|---|
| Normal Neonate Birth | 593 | 9.83% |
| Vaginal delivery | 384 | 6.36% |
| Septicemia & Disseminated Infections | 333 | 5.52% |
| Major Depressive Disorders | 314 | 5.20% |
| Bipolar disorders | 267 | 4.42% |
| Major Resp Infect & Inflam | 243 | 4.02% |
| Cesarean delivery | 239 | 3.96% |
| Heart failure | 210 | 3.48% |
| Knee joint replacement | 181 | 3.00% |
| Depression Exc Mdd | 175 | 2.90% |

#### TOP DISCHARGES BY COMMUNITY IN FY21

| Community[6] | Discharges | Percent of Total Community Discharges |
|---|---|---|
| Amesbury, MA | 1,003 | 58% |
| Newburyport, MA | 951 | 57% |
| Haverhill, MA | 660 | 8% |
| Salisbury, MA | 615 | 62% |
| Merrimac, MA | 285 | 45% |
| Georgetown, MA | 171 | 23% |
| Rowley, MA | 165 | 27% |
| Groveland, MA | 159 | 24% |
| Newbury, MA | 157 | 55% |
| Seabrook, NH | 152 | 40% |

For descriptions of the metrics, please see the technical appendix.
[1] Data from the FY2017 through FY2021 CHIA Cost Reports and Financial Statements.
[2] High Public Payer Hospitals (HPPH) reported a minimum of 63% of gross patient service revenue from public payers.
[3] Effective FY 2020 supplemental revenue is not included in net patient service revenue for all hospitals. Prior to FY 2020, reporting of supplemental revenue varied by hospital.
[4] There was an accounting change adopted by most hospitals beginning in FY 2020 in which unrealized gains and losses on investments are now recognized as non-operating income.
[5] Federal and State COVID-19 relief funding was distributed to hospitals as part of the Coronavirus Aid, Relief, and Economic Security (CARES) Act beginning in FY2020. A portion of this funding was reported as operating revenue.
[6] Inpatient cases and communities with less than 25 discharges have been omitted from the Top Discharges by Inpatient Case (DRG) and Top Discharges By Community charts.
[7] As Beth Israel Lahey Health became financially consolidated in March 2019, seven months of financial data was reported for FY 2019 for this hospital.

**Endnotes**

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i Data refinement is the process of transforming raw and unstructured data into clean and structured formats. The purpose of data refinement is to enhance the usability and relevance of data, so that they can be accessed, analyzed, and interpreted by stakeholders. Data refinement can be applied along a continuum of levels, and in various forms. For example, raw data could be refined sequentially into aggregated line-list data, an interactive dashboard, a static report, a single data-visualization graphic, and then a single statistic. An important consideration is that each successive level of refinement involves a tradeoff between interpretability and flexibility. Although a single statistic is easier than raw data to interpret, many more analyses and insights can be derived from raw data than can be derived from a single statistic. Because this tradeoff is inherent, a best practice for achieving transparency is to ensure that data are published in multiple formats that span levels of refinement – and at least include the lowest level of refinement that can be shared.

ii Seven other states have similarly organized their health data, information, and policy analysis infrastructure around a state health expenditure growth target.

iii There are other State entities that are involved in healthcare delivery in New York whose data may not be publicly available or consistently reported, but which could support important analyses. These include the New York State Health Insurance Program which covers over 1.2 million lives, and the healthcare services provided by the New York State Department of Corrections and Community Supervision.

iv A fully integrated approach to improving health outcomes and the health care delivery system also requires capturing health-related information that reflects social determinants of health. Best practice efforts to develop a "health" data and information infrastructure increasingly will work to capture such information.

v It also appears likely that New York will need to develop aspects of a stronger health data and information infrastructure as part of its pending 1115 Waiver.

vi Ten Years of the Massachusetts Health Policy Commission  at 4:50-5:30.

vii See, e.g., "CHIA: Using Data and Analytics to Support Healthcare Policy Center For Health Information And Analysis," Ray Campbell, Presentation for the Massachusetts Health Policy Forum January 5, 2021.

viii The Center for Health Information and Analysis (CHIA) was established under Section 20 of Chapter 12C of the Massachusetts General Laws.

ix CHIA also collects patient-level data from Massachusetts acute care hospitals. Three main data types constitute the Case Mix Database: Hospital Inpatient Discharge Database (HIDD); Outpatient Observations Database (OOD); and Outpatient Emergency Department Database (ED).

x As described in the CHIA website: "The Case Mix data includes detailed information on inpatient discharges, emergency department visits and observation stays. For each of these patient encounter types, hospitals submit detailed information, including: patient demographics, admission and discharge information, diagnostic and procedural coding, provider details and detailed charge information."

xi Why Are Hospital Prices Different? An Examination Of New York Hospital Reimbursement, Gorman Actuarial, 2016.

xii see, e.g., Anna Jacques Hospital Profile.

xiii See, e.g., Ten Years of Cost Containment in Massachusetts: A Decade of Advancing a More Transparent, Accountable, and Equitable Health Care System

xiv Health Care Cost Growth Benchmark

xv How the Massachusetts Health Policy Commission is Fostering a Statewide Commitment to Contain Health Care Spending

xvi Minnesota Takes Steps to Open the "Black Box" of Health Care Spending Amid Industry Opposition

[xvii] The Massachusetts Health Care Cost Growth Benchmark and Accountability Mechanisms: Stakeholder Perspectives

[xviii] How the Massachusetts Health Policy Commission Is Fostering a Statewide Commitment to Contain Health Care Spending Growth

[xix] 2022 Health Care Cost Trends Report and Policy Recommendations

[xx] Although New York's health agencies produce numerous reports in response to legislative directives, the fact that they are not integrated within a broader framework of analysis hampers their impact. At least some of these studies could more effectively be produced by the staff a permanent health policy research entity.[xx]

[xxi] Minnesota Takes Steps to Open the "Black Box" of Health Care Spending Amid Industry Opposition