March 23, 2018

Dear Senators Bill Cassidy, M.D. (R-LA), Michael Bennet (D-CO), Chuck Grassley (R-IA), Tom Carper (D-DE), Todd Young (R-IN), and Claire McCaskill (D-MO),

Thank you for the opportunity to provide responses to the questions posed in the February 28, 2018, Health Care Price Transparency Initiative letter. On behalf of the APCD Council, we commend your goal "to empower patients, improve the quality of health care, lower health care costs" and your support of transparency as key to being able to successfully achieve those goals.

The All-Payer Claims Database (APCD) Council, is a learning collaborative of government, private, non-profit, and academic organizations focused on improving the development and deployment of state-based all payer claims databases (APCDs). The APCD Council is convened and coordinated by the Institute for Health Policy and Practice (IHPP) at the University of New Hampshire (UNH) and the National Association of Health Data Organizations (NAHDO).

The leadership team for the APCD Council respectfully submits the following feedback, in response to your specific questions. We have focused on states' efforts to drive transparency, understanding that there is a broader universe of stakeholders who will likely comment with their own unique lens.

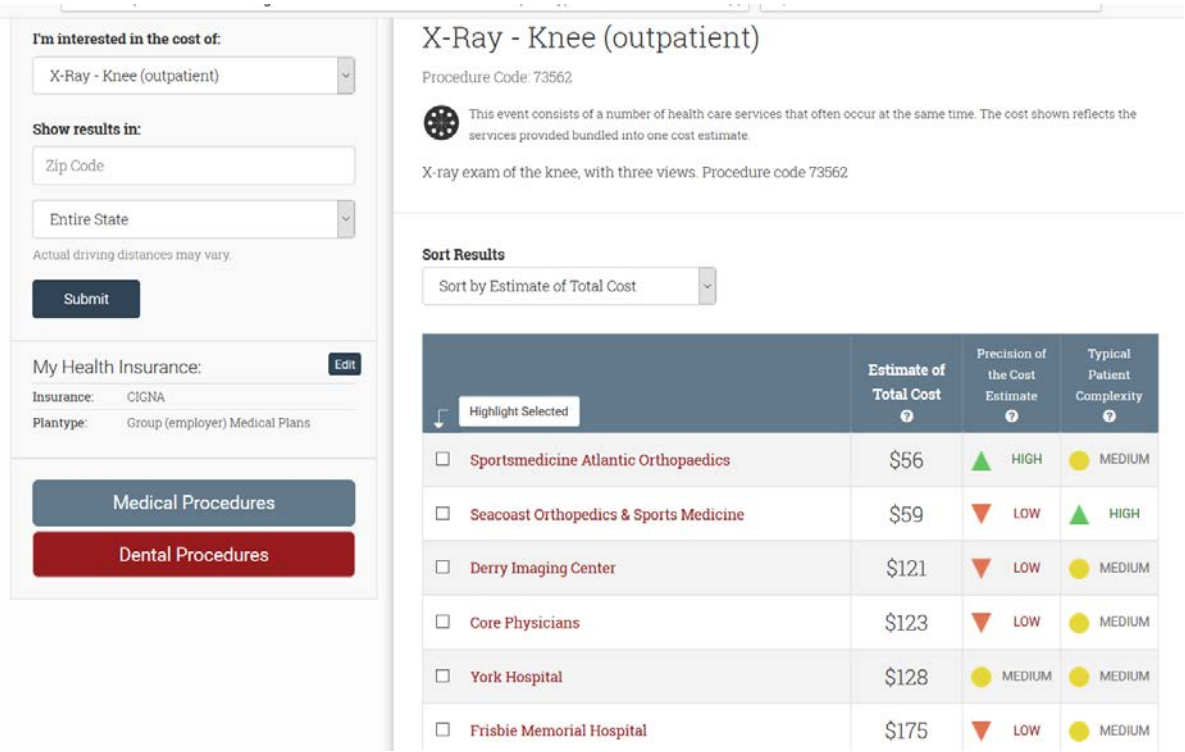
We also welcome the opportunity for more discussion with you and your teams, about any of our comments, or about additional questions you may have. We would also be very interested in participating in the roundtable conversations you are planning or in other venues, as you deem helpful.

1. **What information is currently available to consumers on prices, out-of-pocket costs, and quality?**

As articulated in the letter requesting comments, the health care industry, is unique in how consumers make decisions about how and where to purchase services. Relative to other services for which consumers pay, there is relatively little comparison shopping for health care services. Health care has not historically been an industry where the consumer evaluates various providers in making a decision about where to receive care. Research released in April 2017 found that over half of Americans were not aware that doctor or hospital prices vary. This study also found that consumers are increasingly seeking out price information. The study

reported that 50 percent of Americans have tried to find health care price information before getting care, including 20 percent who have tried to compare prices across multiple providers[1].

Health care, as an industry, is unique in the way prices are established. The price for the same service can vary widely. Determining the price for a service is not a simple exercise, yet many states are making strides to provide price information to consumers. The example below, from the NH HealthCost website from the New Hampshire Insurance Department[2], shows that an X-ray of the knee (using the same procedure code) can vary three-fold in cost, for a person covered by group health insurance from a single insurer, depending on location of the service.



This example from New Hampshire highlights the utility of developing data systems to collect data to support health care system transparency. States have over 30 years' experience developing Hospital Discharge Data Systems (HDDS; see www.nahdo.org for a list of states with HDDS) and using those data to support transparency in health care. States have been developing All-Payer Claims Databases (APCD) for over 10 years (see www.apcdcouncil.org for a

[1] https://nyshealthfoundation.org/wp-content/uploads/2017/11/how-people-use-health-care-price-information-full-report.pdf
[2] www.nhhealthcost.com

list of states with APCDs). The two statewide health care data systems are discussed in more detail in the sections below.

All-Payer Claims Databases (APCDs)

APCD data have been used to support transparency efforts related not only to consumer tools that focus on price and costs of services, but also a range of analyses to support health policy and clarity to support consumer-focused public policy, more generally. This includes:

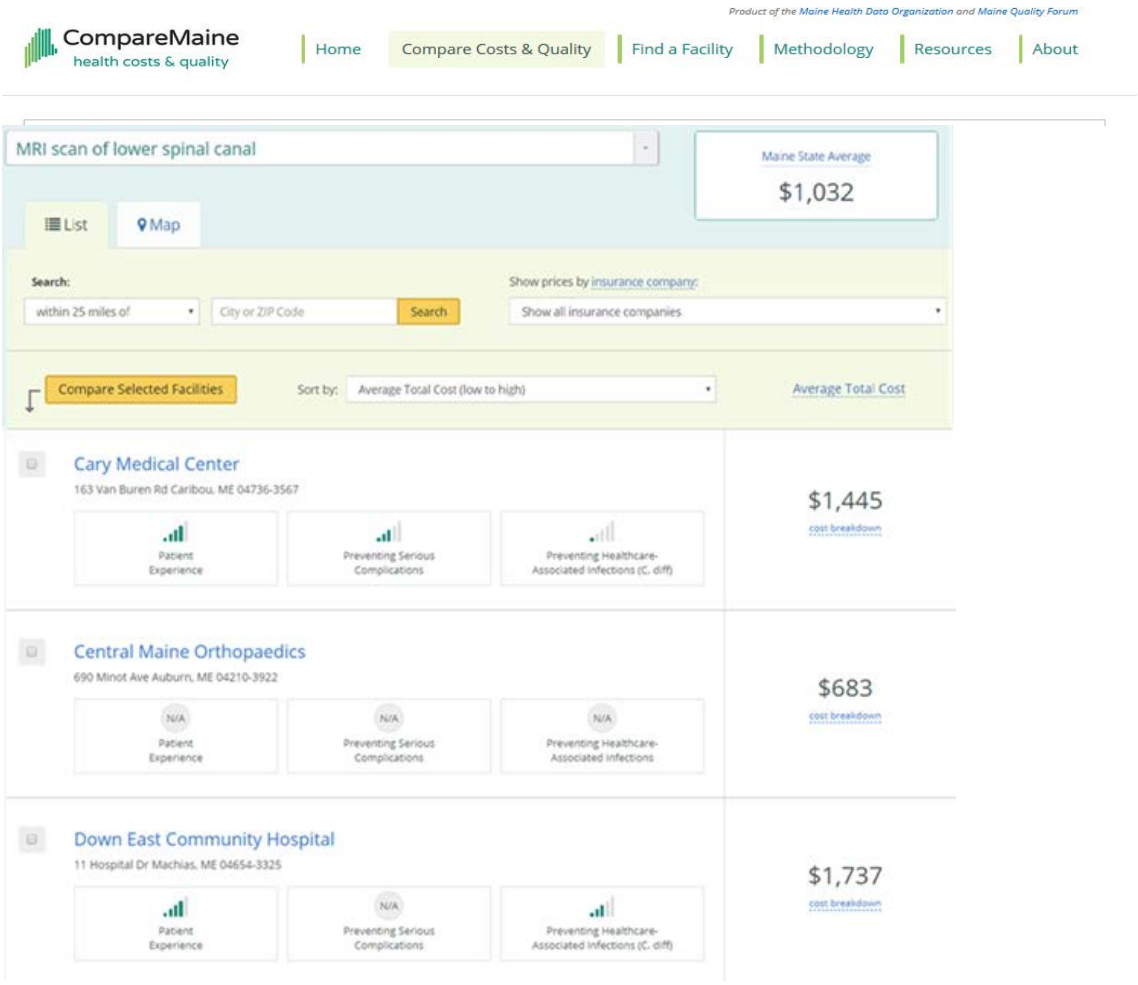
- **Assessing geographic variations in price and utilization.** The Oregon Health Authority publishes quarterly reports that compare per-member per-month costs and utilization, by service category, for commercially insured, public employees, and public payers (http://www.oregon.gov/oha/hpa/analytics/pages/index.aspx). Colorado uses its APCD to study price variation for common procedures among facilities (http://www.civhc.org/get-data/interactive-data/statewide-metrics/cost-of-care/). Maryland uses APCD data to compare the unit-costs, utilization, per-member per-month costs, out-of-pocket and insurance payments, geographic variations, and physician access data across geographic regions (http://mhcc.maryland.gov/transparency/Default.html).
- **Tracking health care spending drivers and trends.** Massachusetts uses its APCD data to produce an annual report analyzing trends in in health care spending for commercial payers by category of service, type of episode, and geographic area (http://www.mass.gov/anf/docs/hpc/apcd-almanac-chartbook.pdf). Minnesota has used its APCD data to analyze prescription drug spending by therapeutic category and setting (office-administered vs. pharmacy benefit)(http://www.health.state.mn.us/healthreform/allpayer/20160229_rxtrends.pdf). Rhode Island released a report analyzing the top 15 clinical complaints and associated costs of potentially avoidable emergency room visits broken down by payer type (http://health.ri.gov/data/potentiallypreventableemergencyroomvisits/)
- **Promoting public health.** Organizations in Virginia (http://www.vhha.com/research/2016/01/29/data-show-southwest-virginia-hard-hit-by-opioid-crisis/) and Utah (http://healthinsight.org/files/Utah%20Partnership%20for%20Value-Driven%20Healthcare/Transparency%20Advisory%20Group/In-Person%20Events/TAG%20Slides%204-19-16%20final.pdf) have used APCD data to track opioid prescription claims across geographic areas and patient characteristics to understand and address trends in opioid use as have the Agency for Healthcare Research and Quality (https://www.hcup-us.ahrq.gov/datainnovations/Opioid_trends_ICD_Med_Care.pdf) . New Hampshire used APCD data to measure access to and utilization of preventive services, such as cancer

screening or diabetic testing and treatment, among its adult Medicaid population (https://www.dhhs.nh.gov/ombp/documents/adultpreventivebrief.pdf)

- States are using their data systems to improve outcomes and reduce costs associated with avoidable inpatient and Emergency Department visits and hospital readmissions (https://profiles.health.ny.gov/measures/all_state/16284)

More specifically related to the question about price and cost information for consumers, states have developed many exemplary tools using APCD data. The example above demonstrates NH's consumer tool. Additional state tool examples include:

Maine's CompareMaine site: *http://www.comparemaine.org/*



Maryland's WearTheCost site: http://healthcarecost.mhcc.maryland.gov/

These tools provide comparative information about the cost for selected services, typically focusing on services for which people have time and ability to choose where to receive care. The full functionality of these tools is beyond the scope of these comments, and we encourage you to spend time using the tools to understand how they can be used to assist consumers.

In terms of information related to quality of care, several of the above tools also incorporate aspects of health care quality into the consumer tools. The tools incorporate such quality dimensions as complications, health care associated infections, and patient experience.

Hospital Discharge Data Sets (HDDS)

Another source of rich quality information stems from statewide hospital discharge data sets. These data sets capture all discharges from all acute care facilities in a state for all patients (regardless of payer, including uninsured and self-pay), providing key information on the sickest, costliest populations in a state. Beginning with the landmark Coronary Artery Bypass Graft outcomes reports in New York and Pennsylvania in the early 1990's, other states have followed with their own provider quality reports.

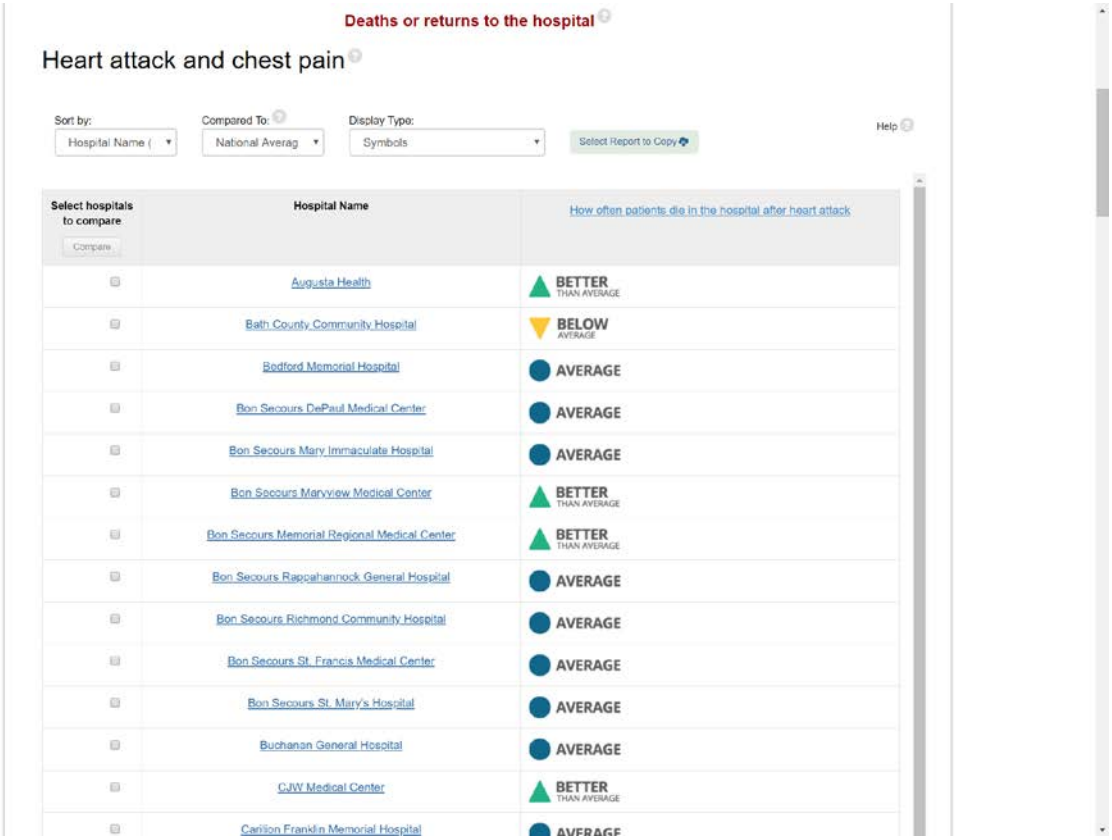
Almost every state has some form of statewide hospital reporting system, with many releasing public reports or maintaining websites with quality comparisons. Research indicates the "making performance data public results in improvements in the clinical area reported upon and that consumer surveys suggest that inclusion did affect hospitals' reputations".[3] "Widespread reporting of hospital performance has been shown to drive improvements." "Making performance information public appears to stimulate quality improvement activities in areas where performance is reported to be low[4]" with availability of statewide hospitalization data as underpinnings of quality studies.

Many states use the Agency for Healthcare Quality and Research (AHRQ) Quality Indicators—standardized measures and benchmarks of health system and hospital performance with open-source software capabilities. (http://www.qualityindicators.ahrq.gov/). It is important to note that while measures and analytic tools are important to public reporting, the underlying data source must be available---collected, audited/validated, and standardized in order to produce these measures of quality.

States publish their hospital quality data in reports and websites (too numerous to list here). Examples include:

- **Virginia Health Information (VHI):** VHI's hospital quality website published four types of quality ratings on the site: recommended care, results of care, patterns of how care is delivered, and patient experience. This site shows hospitals' quality ratings on several different topics, including patient safety and specific health conditions. The following depicts ratings on hospital deaths and readmissions for heart attack and chest pain patients: http://www.vhi.org/monahrq2014/index.html#/professional/quality-ratings/condition?topic=8&subtopic=22

[3] Health Affairs, July/August 2005: https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.24.4.1150
[4] Health Affairs, March/April 2003: https://pdfs.semanticscholar.org/3c46/1fcc32f7e817a71efc171995c24695b3d9ce.pdf



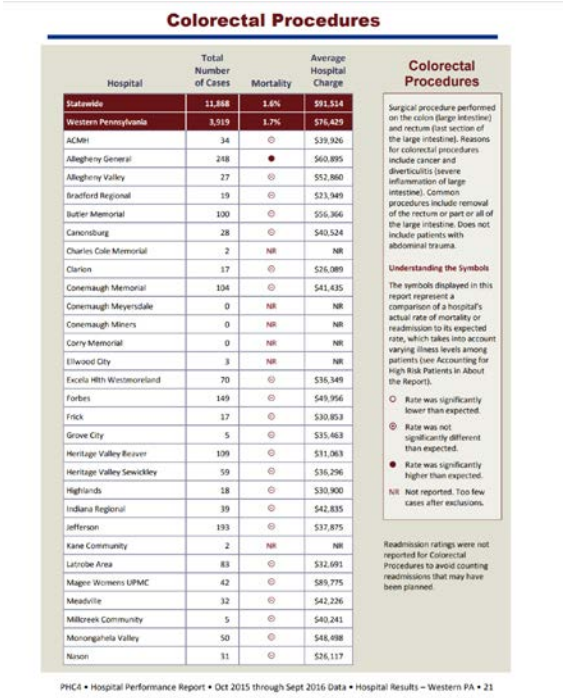
Deaths or returns to the hospital

Heart attack and chest pain

Sort by: Hospital Name (| Compared To: National Averag | Display Type: Symbols | Select Report to Copy | Help

Select hospitals to compare (Compare)	Hospital Name	How often patients die in the hospital after heart attack
	Augusta Health	BETTER THAN AVERAGE
	Bath County Community Hospital	BELOW AVERAGE
	Bedford Memorial Hospital	AVERAGE
	Bon Secours DePaul Medical Center	AVERAGE
	Bon Secours Mary Immaculate Hospital	AVERAGE
	Bon Secours Maryview Medical Center	BETTER THAN AVERAGE
	Bon Secours Memorial Regional Medical Center	BETTER THAN AVERAGE
	Bon Secours Rappahannock General Hospital	AVERAGE
	Bon Secours Richmond Community Hospital	AVERAGE
	Bon Secours St. Francis Medical Center	AVERAGE
	Bon Secours St. Mary's Hospital	AVERAGE
	Buchanan General Hospital	AVERAGE
	CJW Medical Center	BETTER THAN AVERAGE
	Carilion Franklin Memorial Hospital	AVERAGE

- **Pennsylvania Health Care Cost Containment Council (PHC4):** PHC4 publishes hospital performance reports and makes downloadable data sets available to the public (www.PHC4.org). An example, below, reports the volume of admissions for colorectal procedures (volume of patients treated can be a proxy measure predicting outcome, with higher volume associated with better outcomes), the mortality rate for those treated, and the average hospital charge, which does not reflect costs but which is a benchmark or reference list price to negotiate payment rates with insurers.



Colorectal Procedures

Hospital	Total Number of Cases	Mortality	Average Hospital Charge
Statewide	11,888	1.6%	$91,514
Western Pennsylvania	3,919	1.7%	$76,429
ACMH	34	○	$39,926
Allegheny General	248	●	$60,895
Allegheny Valley	27	◎	$52,860
Bradford Regional	19	◎	$23,949
Butler Memorial	100	◎	$56,366
Canonsburg	28	◎	$40,524
Charles Cole Memorial	2	NR	NR
Clarion	17	◎	$26,089
Conemaugh Memorial	104	◎	$41,435
Conemaugh Meyersdale	0	NR	NR
Conemaugh Miners	0	NR	NR
Corry Memorial	0	NR	NR
Ellwood City	3	NR	NR
Excela Hlth Westmoreland	70	◎	$36,349
Forbes	149	◎	$49,956
Frick	17	◎	$30,853
Grove City	5	◎	$35,463
Heritage Valley Beaver	109	◎	$31,063
Heritage Valley Sewickley	59	◎	$36,296
Highlands	18	◎	$30,900
Indiana Regional	39	◎	$42,835
Jefferson	193	◎	$37,875
Kane Community	2	NR	NR
Latrobe Area	83	◎	$32,691
Magee Womens UPMC	42	◎	$89,775
Meadville	32	◎	$42,226
Millcreek Community	5	◎	$40,241
Monongahela Valley	50	◎	$48,498
Nason	31	◎	$26,117

Colorectal Procedures

Surgical procedure performed on the colon (large intestine) and rectum (last section of the large intestine). Reasons for colorectal procedures include cancer and diverticulitis (severe inflammation of large intestine). Common procedures include removal of the rectum or part or all of the large intestine. Does not include patients with abdominal trauma.

Understanding the Symbols

The symbols displayed in this report represent a comparison of a hospital's actual rate of mortality or readmission to its expected rate, which takes into account varying illness levels among patients (see Accounting for High Risk Patients in About the Report).

○ Rate was significantly lower than expected.

◎ Rate was not significantly different than expected.

● Rate was significantly higher than expected.

NR Not reported. Too few cases after exclusions.

Readmission ratings were not reported for Colorectal Procedures to avoid counting readmissions that may have been planned.

PHC4 • Hospital Performance Report • Oct 2015 through Sept 2016 Data • Hospital Results – Western PA • 21

As valuable as hospital discharge data systems have been for driving industry quality improvement, consumers have not been the direct users of hospital quality data. In addition to lack of awareness of its availability or how these data can be used, many consumers do not "shop" for hospital services because of network restrictions and hospital data do not include actual costs and estimates of patient liability. APCDs supplement HDDS to fill this information gap.

2. What information is not currently available, but should be made available to empower consumers, reduce costs, increase quality, and improve the system?

There continue to be important gaps in publicly-available comparative information, including:

Provider and provider-group level data: Consumers seek reliable and independently-validated information at the provider or provider-group level. States expend considerable resources on provider identification and mapping providers into practice groups, due to limits on physician identifiers. Further, attributing individual patients to specific physicians is a difficult process due to limitations in the claims reimbursement process in which the billing provider may not be the service provider.

Data related to behavioral health or substance use disorder treatment: Some data submitters, particularly to state APCDs, have interpreted rules from the Substance Abuse and Mental Health Services Administration (SAMHSA) related to data sharing (42 CFR Part 2 Confidentiality of Substance Use Disorder Patient Records[5]), very broadly to remove data that are critical to understanding availability and costs of services related to behavioral health and substance use disorder treatment. The missing data hinders a state's ability to assess and shape opioid intervention policies and activities.

Given certain policy barriers, there are some consumers who may not be included in data collection efforts at the state APCD. This includes:

Some consumers covered by self-funded insurance plans: The United States Supreme Court Decision in *Gobeille vs. Liberty Mutual* ruled that self-funded employers covered by ERISA cannot be legally obligated to have their data submitted to a state APCD. Employers can opt in to data collection efforts, but cannot be mandated to do so. This issue is discussed further in question 9, below.

Federal Employee Health Benefits Program (FEHBP) and Tricare Data: Not all data from plans that are administered for Federal employees or Military personnel submit data to state APCDs.

3. What role should the cash price play in greater price transparency? How should this be defined?

Given the variation in costs and the fact that negotiations are tied to insurance contracts, cash prices may not be terribly meaningful for consumers. Few (if any) people pay a set "price" that is standard at a facility, for a service. Instead, the price paid will depend on a set of negotiations, either by the payer or the individual. It is unclear if this metric can provide real transparency or decision-making support.

Best practice transparency information includes cost data that represents the total amount paid for a service by both consumer and insurers, an allowed amount that indicates the amount that has been negotiated as what is "allowed" to be paid for that service.

[5] https://www.samhsa.gov/health-information-technology/laws-regulations-guidelines

Although not the same as cash price, one lesson learned from state-level analysis is that variable and potentially expensive out-of-pocket costs, such as deductibles and coinsurance, is important information for consumers. As cost-sharing increases for consumers, this information can be useful for decision-making and planning for health care expenses. Research has shown that insured Americans with high deductibles are more likely to have tried to find price information before getting care. Sixty-nine percent of insured Americans with deductibles above $3,000 have tried to find price information while only 50 percent of those with deductibles less than $500 have done so.[6]

4. **Different states have used different methods to work towards price transparency. What are the pros and cons of these different state approaches? What is the best quality and price information to collect for consumers and businesses?**

Public reporting initiatives navigate a delicate balance between concerns about sharing information considered proprietary with the need to inform the public and provide comparative performance information. While both private and public organizations play roles in transparency, states play a significant role. Responsible for health care oversight and protection of their citizens, state agencies have been collecting and using health care system data for over 30 years and have established ample evidence that a community data system has a positive influence on the market and can support informed policy decisions.

While states have adapted approaches to statewide data collection to reflect their local market and political environments, there are remarkable similarities in the statewide reporting programs, especially in the data elements they capture. For example, most states collect hospital and claims data under legislative authority; some states without such legislation rely on voluntary submission by providers and payers. The governance approach may influence the comprehensiveness of the data collected and its access to the general public. State hospital and APCD reporting legislation typically authorizes the state agency or health data authority to collect and manage data, either internally or through contracts with external vendors. Legislation grants legal authority to enforce penalties for noncompliance and other violations, while separate regulations define reporting requirements. State legislation typically establishes the authority for, and scope of, data collection. The table below indicates how approaches may differ and how these approaches influence key aspects of data practices.

[6] https://nyshealthfoundation.org/wp-content/uploads/2017/11/how-people-use-health-care-price-information-full-report.pdf

Summary of State Approaches to Data Governance

	Data Collection	Data Oversight	Transparency at provider level	Comment
Mandatory/required by law	Compliance to reporting requirements with penalties for non-compliance	Data release governed by law/oversight committee policies	Reporting policies defined by law and regulation and more likely to result in release of provider-level reporting	The majority of states adopt a mandated reporting approach for hospital and APCD systems
Voluntary reporting	Reliance on voluntary submission	Varies	Varies according to submitter support	Voluntary initiatives rely on submitter support

State approaches to using data to support transparency vary, because there is no "one size fits all" approach. Some states have requirements for how data are to be used in their legislation or in other regulation. For example:

The legislation that established the APCD in Colorado states: "The All-Payer Health Claims Database shall: (a) Be available to the public when disclosed in a form and manner that ensures the privacy and security of personal health information as required by state and federal law, as a resource to insurers, consumers, employers, providers, purchasers of health care, and state agencies to *allow for continuous review of health care utilization, expenditures, and quality and safety performance* in Colorado." (italics added)[7]

Massachusetts' Chapter 224 of the Acts of 2012, "An Act Improving the Quality of Health Care and Reducing Costs Through Increased Transparency, Efficiency and Innovation," created the Center for Health Information and Analysis (CHIA), which develops an annual report of health care system performance across Massachusetts.[8]

7
http://www.leg.state.co.us/CLICS/CLICS2010A/csl.nsf/fsbillcont3/7772EFE1E998E627872576B700617FA4?Open&file=1330_enr.pdf

8 http://www.chiamass.gov/ma-apcd/

As the health care system evolves, what is and becomes ***"the best quality and price information to collect for consumers and businesses"*** may need to change to match the changing landscape. What is critical is to create the ongoing collection of detailed data that can be configured to meet a variety of needs, including granular or detailed data to support local-level decisions by purchasers, consumers, as well as policy makers. Data systems that are available to authorized parties and developed with broad stakeholder input and with open and transparent methods and policies are necessary to achieve real transparency.

5. **Who should be responsible for providing pricing information and who should share the information with consumers?**

A broad array of partners should play a role in providing pricing information and sharing this information with consumers. However, the competitive nature of the health care market is one of the greatest barriers to data sharing and reporting, as some information (e.g., contracted rates) may be considered proprietary. Thus, states have a key role because of their legislative authority and ability to compel reporting across players as well as incorporating all local stakeholders in designing the data system and policies governing the data. Although difficult, states have demonstrated it is possible to establish a data commons with useful information for both industry and the public.

But states alone cannot bear the entire burden of supporting people to be effective health care consumers. Such an effort will require a multi-faceted approach. Employers, providers, payers, advocacy organizations, policy makers, and others all play a role. While there are many important players efforts to support transparency, states will continue to have a crucial and central role. Research has shown that the vast majority (80%) "think it is important for their state governments to provide people with comparative price information."[9]

6. **What role should all-payer claims databases play in increasing price and quality transparency? What barriers currently exist to utilizing these tools?**

APCDs are the only statewide data source for a state that captures the utilization and costs **across** payers and providers in a state, including pharmacy, physician, and dental data. APCD data systems are robust enough to allow granular data analysis to support local-level information. Our comments to the previous questions demonstrate several of the roles that ACPDs can play in the efforts to improve transparency for consumers, as well as to the larger

[9] https://nyshealthfoundation.org/wp-content/uploads/2017/11/how-people-use-health-care-price-information-full-report.pdf

health care stakeholder community. As discussed, APCDs have been used in many ways to improve health care system, from tools directed to consumers to broader views into the health care system to inform policy to support health improvement. APCDs have a key role in regulation, consumer support, population health improvement, and planning for system change. The APCD Use Case Showcase (www.apcdshowcase.org) demonstrates a much broader set of examples than can be described in this response.

The greatest barrier to state APCD development is the lack of funding to establish and sustain reporting programs. Federal engagement in partnership with states is needed to fill critical gaps in data collection, to assure that the data can include as many people as possible, and to support the widest range of needs possible.

7. **How do we advance greater awareness and usage of quality information paired with appropriate pricing information?**

States are poised and interested in being active partners with other organizations to assure the public availability and effective use of the data being collected. The tools and information being made available by the states can be coupled with education and awareness efforts from other stakeholders.

In addition, maximizing the potential of the data relies on robust data sources. It is critical to invest in the data systems to ensure that adequate funding and resources are available to establish and sustain a viable ongoing system of data collection and reporting. We suggest that federal agencies have an opportunity to more fully support development of best practices in data management and quality assurance/validation of the data and assist in the promulgation of these practices and tools across state initiatives. There are also opportunities to support commonality and relevancy in development of consumer-oriented information, such as shared investments in website and mobile application development geared to consumer use.

8. **How do we ensure that in making information available we do not place unnecessary or additional burdens on health care stakeholders?**

A critical aspect to minimizing burden is to leverage the claims payment transaction infrastructure, which is the foundational premise of the APCDs. APCDs rely on relatively standardized data feeds, reducing the burden on individual payers to report, and provide wide-angle views of the health care delivery system's performance. Also, strategic linkage of state claims-based data with clinical information will enhance the value of the data without imposing additional abstraction burden on clinicians. States are demonstrating the feasibility of such

linkage, but states alone cannot develop a policy and technical infrastructure to support ongoing and effective linkage across data sources without federal support.

9. **What current regulatory barriers exist within the health care system that should be eliminated in order to make it less burdensome and more cost-efficient for stakeholders to provide high-quality care to patients?**

Self-funded data collection: As previously mentioned, the SCOTUS ruling in *Gobeille vs. Liberty Mutual* held that ERISA pre-empts certain self-funded insurers from submitting data to the state mandated APCDs. That ruling discussed the ability of DOL to use its authority to create a mechanism for data collection. Justice Breyer commented: "I see no reason why the Secretary of Labor could not develop reporting requirements that satisfy the States' needs including some state-specific requirements, as appropriate."[10] In response, the APCD Council leaders, NAHDO and UNH, as well as NASHP submitted comments to a DOL rule that provides a path for these data to be collected. [11] There are also modifications that can be made to ERISA as a solution to the issue.

FEHBP data submission: There are allowances that can be made by the Office of Management and Budget to streamline data submission from plans for Federal Employees.

42 CFR Part 2: There are clarifications that can be made by SAMHSA to provide assurances of the allowance of the submission of behavioral health and substance use disorder claims to state entities.

10. **How can our health care system better utilize big data, including information from the Medicare, Medicaid, and other public health programs, to drive better quality outcomes at lower costs?**

No one data set or data system will serve all of the needs of every user or supply information for every use. As information needs grow through value-based purchasing, population health management, and consumer transparency uses, policy makers and industry need to move beyond siloed and fragmented data sets to strategic approaches that include data sharing and data partnerships that leverage existing data assets more effectively. For example, states capture important information for their own policy and market uses (population health,

[10] http://www.scotusblog.com/case-files/cases/gobeille-v-liberty-mutual-insurance-company/
[11] https://nashp.org/wp-content/uploads/2016/10/CA_-Final_-NASHP-Comments-and-Proposal-to-DOL.pdf

transparency, policy evaluation), yet these data sets capture important information such as Medicare Advantage encounters that should be of interest to CMS (which CMS does not routinely obtain). Strategic data exchange and data linkage will enhance the information that is already available without duplicating expensive data collection initiatives. For example, some states are linking claims with clinical information to develop robust risk assessment and performance evaluation reimbursement practices. Our comments have illustrated a range of data reports, information, tools, and data uses that inform can inform cost containment and quality improvement projects. These uses can be coupled with efforts around dissemination and education to maximize the use of the data.

11. What other common-sense policies should be considered in order to empower patients and lower health care costs?

A coalition of state and national payers, coordinated by the APCD team, have harmonized APCD reporting data elements and formats across states, known as the Common Data Layout (CDL).[12] Policy efforts that focus on implementing the CDL in order to fill data gaps, as well as maintain and update and implement the common reporting formats, will reduce reporting burden and improve comparability of claims-based data across states. This effort has not been implemented due to a combination of factors: 1) Department of Labor delay in enacting a final reporting rule and 2) lack of funding to support the finalization and maintenance of the APCD reporting standard.

State and private reporting initiatives will benefit from shared solutions to common technical issues, where possible. Seeking common solutions to cross-cutting issues will benefit all. This includes:

a. Physician identifiers and attribution
b. Common approaches to data quality/claims data edit logic
c. Open-source measures and tools, such as episodes of care, consumer transparency tools, and quality measures

Resolutions to these barriers to enhanced health care transparency are not insurmountable, but states alone cannot solve them without federal collaboration. We recommend that federal-state partnership is needed to support continued development and commonality in claims-based data collection and use.

[12] https://www.apcdcouncil.org/standards

We respectfully submit this feedback for your consideration as you move forward with your Health Care Price Transparency Initiative. We are available for further discussion.

Sincerely,

Denise Love, BSN, MBA
dlove@nahdo.org
Executive Director
National Association of Health Data Organizations
801-532-2262

Josephine Porter, MPH
Jo.Porter@unh.edu
Director
Institute of Health Policy and Practice, UNH
603-862-2964

List of Resources Cited in this Response:

www.nahdo.org
www.apcdcouncil.org
www.apcdshowcase.org
http://www.oregon.gov/oha/hpa/analytics/pages/index.aspx
http://www.civhc.org/get-data/interactive-data/statewide-metrics/cost-of-care/
http://mhcc.maryland.gov/transparency/Default.html
http://www.mass.gov/anf/docs/hpc/apcd-almanac-chartbook.pdf
http://www.health.state.mn.us/healthreform/allpayer/20160229_rxtrends.pdf
http://health.ri.gov/data/potentiallypreventableemergencyroomvisits/
http://www.vhha.com/research/2016/01/29/data-show-southwest-virginia-hard-hit-by-opioid-crisis/
http://healthinsight.org/files/Utah%20Partnership%20for%20Value-Driven%20Healthcare/Transparency%20Advisory%20Group/In-Person%20Events/TAG%20Slides%204-19-16%20final.pdf
https://www.hcup-us.ahrq.gov/datainnovations/Opioid_trends_ICD_Med_Care.pdf
https://www.dhhs.nh.gov/ombp/documents/adultpreventivebrief.pdf
https://profiles.health.ny.gov/measures/all_state/16284
http://www.comparemaine.org/
http://healthcarecost.mhcc.maryland.gov/
https://nyshealthfoundation.org/wp-content/uploads/2017/11/how-people-use-health-care-price-information-full-report.pdf
www.nhhealthcost.com
https://nyshealthfoundation.org/wp-content/uploads/2017/11/how-people-use-health-care-price-information-full-report.pdf
http://www.chiamass.gov/ma-apcd/
https://nyshealthfoundation.org/wp-content/uploads/2017/11/how-people-use-health-care-price-information-full-report.pdf
http://www.scotusblog.com/case-files/cases/gobeille-v-liberty-mutual-insurance-company/
https://nashp.org/wp-content/uploads/2016/10/CA_-Final_-NASHP-Comments-and-Proposal-to-DOL.pdf
https://www.apcdcouncil.org/standards