

## *Enhancements to HHS Surveys to Measure Health System Change*

### **Overview**

The surveys and major data collection systems sponsored by the Department of Health and Human Services (HHS) are critical to HHS policy and program decision making. These systems also provide most of the national statistical capacity to monitor the health and wellbeing of the population and the functioning of the health care, public health and human services programs. HHS holds the stewardship responsibility for these core statistical and data systems and is both a producer and user of the timely, high quality data that they generate.

In order to monitor the implementation and impact of health reform and other health system changes, HHS has taken a number of steps to modify and enhance several of the surveys and major data systems in the HHS portfolio. Many of the existing HHS surveys and data systems already have the capacity to inform the implementation and assess the impact of health reform. In this paper, we review some of the recent modifications and enhancements planned and, in many cases already implemented, in selected HHS surveys. The work is being coordinated under the auspices of the HHS Data Council and its Working Group on Surveys and Administrative Data for Health Reform Monitoring and Evaluation. The goals of the Working Group are to facilitate information exchange, coordination and planning of survey and administrative data efforts in support of monitoring the implementation and impact of health reform and related policy research and evaluation

### **Data Enhancements**

***Data Collection Standards*** - The Affordable Care Act (ACA) includes several provisions designed to improve data collection and availability. Section 4302 of the Affordable Care Act requires the HHS Secretary to adopt data collection standards for race, ethnicity, sex, primary language and disability status. Data collection standards for population surveys with self-report data were adopted on October 31, 2011, and are being implemented within the major HHS surveys. The new data standards include additional granularity for race and ethnicity, and new, uniform data collection requirements for self-reported language and English proficiency, disability status and sex. The enhanced data resulting from the standards will increase HHS' ability to monitor health reform impacts on population subgroups. The HHS data standards are available at <http://aspe.hhs.gov/datacncl/standards/ACA/4302/index.shtml>.

***Survey Enhancements*** - HHS sponsors surveys related to US households and the population, health care establishments and providers, employers, and the health care workforce. A Guide to HHS Surveys and Major Data Resources is available at <http://aspe.hhs.gov/sp/surveys/index.shtml> and includes a brief description and link to each major system. The surveys and data collection systems described below collect the full spectrum of health and health care information, including health status and behaviors, health care access, resources, utilization and expenditures, insurance coverage and financing, and functional status as well as social determinants of health and quality of care.

A brief description of the survey enhancements is provided below, followed by detailed information for each survey:

Data Source	Enhancements to Monitor Health Reform
Behavioral Risk Factor Surveillance System	New questions on insurance coverage and access to care
National Health Interview Survey	Expanded sample; enhanced questions on access and utilization of services
National Ambulatory Medical Care Survey	Expanded physician sample and health center sites; enhanced physician survey questions; mail supplement
National Hospital Ambulatory Medical Care Survey	Expanded sample of emergency departments; look-back module on preventive services
Medical Expenditure Panel Survey Household Component	Additional information on high risk pools, health spending accounts, and flexible spending accounts
Medical Expenditure Panel Survey Insurance Component	Testing of additional potential questions on employer plans and offerings, firm size, self insured plans.
Medicare Current Beneficiary Survey	New questions implementing data standards, preventive services, premiums and cost sharing, Part D changes
Medicare Health Outcomes Survey	Measures for determining quality bonus payment
Consumer Assessment of Healthcare Providers and Systems	Questions and measures for reporting patient satisfaction and quality

## **CENTERS FOR DISEASE PREVENTION AND CONTROL**

### **Behavioral Risk Factor Surveillance System**

The Behavioral Risk Factor Surveillance System (BRFSS) is a State-based, on-going telephone health survey system, tracking health conditions and risk behaviors in the United States yearly since 1984. Currently, data are collected monthly in all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and Guam. To support health reform related monitoring on a State basis, additional questions on health insurance coverage, access to care, and utilization of preventive services are being considered for the core questionnaire of the State-based BRFSS. These questions will improve the ability of the survey to provide information on variations in coverage and access at State and local levels.

### **National Center for Health Statistics**

#### **National Health Interview Survey**

The National Health Interview Survey (NHIS) is based on in home interviews of a probability sample of US households. The survey collects data on health status, access to care, health care utilization, health behaviors, functional status and disability and insurance coverage. The NHIS can be used to produce national estimates on these topics as well as State estimates for the largest States. In 2011, the NHIS introduced two ACA related changes. First, the sample size was expanded to increase the number of States for which estimates can be made. Second, enhanced questions on access and utilization of health care services were added to the ongoing survey to enhance estimates pertaining to provisions in the ACA. These enhancements continue in 2012.

Questionnaire additions included the following topics:

- changes in health care coverage of the age group 19 to 25 years;
- coverage of family members living outside the household;
- coverage of family members in the household by persons living elsewhere;
- whether use of a primary care physician is required by the policy;
- changes in coverage and the quality of coverage;
- the financial burden of medical care;
- attempts at direct purchase of insurance;
- awareness of long term care insurance;
- difficulty finding appropriate care when it is needed;
- emergency department visits;
- why there is no usual source of care; use of preventive services;
- using computers for health information and interactions with medical providers and pharmacies, and
- misuse or nonuse of prescriptions drugs due to cost.

NCHS also maintains an early release program to disseminate preliminary data. These Early Release (ER) reports are designed to highlight timely, new data. There are three periodic ER reports based on the NHIS: health insurance coverage; key health indicators; and cell phone usage. Based on the new access and utilization questions, four additional ER reports were released between January and March 2012 based on the first 6 months of data. The reports covered changes in insurance coverage of persons aged 19 through 25 years; financial burden of prescription drugs; emergency department use; and the financial burden of medical care.

### **National Health Care Provider Surveys**

HHS also conducts a family of health care provider surveys referred to generally as the National Health Care Survey. The family includes the National Ambulatory Medical Care Survey and the National Hospital Ambulatory Medical Care Survey.

The National Ambulatory Medical Care Survey (NAMCS) is a national survey of patient visits to nonfederal office based physicians, as well as physicians and mid-level providers sampled in community health centers. The survey provides information about the provision of ambulatory medical care services in physician offices in the U.S. In 2012, the sample size of NAMCS was increased several fold in order to monitor the effects of changes in the health care system, and to improve our understanding of physician practices related to the management of heart disease and stroke. The new sample design will allow the NAMCS to make State-based estimates for approximately 34 States. The physician induction interview also includes new questions on how long on average it takes a patient to get an appointment and whether the physician sets aside time for same day appointments.

In order to monitor the effect of health reform on physician's acceptance of new patients and patients covered by the ACA, new questions have been added to the physician interview. These questions address physicians' acceptance of new patients, specifically patients with Medicare or Medicaid. Since 2008, NAMCS has included a supplement to track adoption of Electronic Health Records (EHRs) by office based physicians. In 2010 and 2011 the sample was expanded

substantially to allow State specific estimates. A follow-up physician workflow study has been added to obtain additional information on the perceived costs and benefits of EHR.

A new look-back module has been added to the NAMCS to improve the nation's ability to monitor the effects of increased insurance coverage on services provided in physician's offices to prevent heart disease and stroke. This NAMCS module will collect information from the 12 month period prior to the sampled visit on risk factors and clinical management of patients with conditions that put people at risk for heart disease and stroke. NAMCS also is testing the feasibility of collecting information on payments to physicians. The test will assess the feasibility of collecting Current Procedural Terminology (CPT) Codes and provide recommendations for initiating collection of CPT codes in NAMCS and possibly in NHAMCS.

The National Hospital Ambulatory Medical Care Survey (NHAMCS) collects data on the utilization and provision of ambulatory care services in hospital emergency and outpatient departments, and in ambulatory surgery centers. To understand the role of the hospital emergency departments (ED) under health reform, 167 hospital EDs are being added to the NHAMCS sample in five of the most populous States to monitor the potential effect of health reform on ED utilization and wait times.

## **AGENCY FOR HEALTHCARE RESEARCH AND QUALITY**

### **Medical Expenditure Panel Survey**

The Medical Expenditure Panel Survey (MEPS) consists of a family of three interrelated surveys: the Household Component, the Medical Provider Component, and the Insurance Component. MEPS was designed to provide annual national estimates of the health care use, medical expenditures, sources of payment and insurance coverage for the U.S. civilian non-institutionalized population. In addition to collecting data to yield annual estimates for a variety of measures related to health care use and expenditures, MEPS also provides estimates of measures related to health status, demographic characteristics, employment and access to health care.

MEPS content already offers a strong platform in content on the dimensions of cost, coverage, utilization, access and health status that has already provided data to support a number of ACA provisions. For example, MEPS national and State level estimates of average premiums were utilized to estimate the small business tax credits for 2010. Data from the 2009 MEPS Insurance Component were used to provide estimates of health insurance premiums by State for employer sponsored coverage provided by small employers of size 50 or less. The small employer health insurance tax credit was then determined based on the MEPS derived estimates of the average premium for the small group market in each State for the 2010 taxable year and was posted on the IRS website.

MEPS is also being used to monitor the health insurance status of young adults, ages 22-25. The MEPS will continue to be utilized to discern the changes in health insurance coverage take-up in this population that are attributable to ACA related changes that took effect in 2010. In addition, MEPS will be utilized to assess changes in health care access, related health care utilization, out of pocket and total expenditures incurred by such young adults as a consequence of this legislation and its impact on health status.

With respect to recent ACA related enhancements, MEPS has made the following modifications.

- High Risk Pools – “High Risk Pool” was added to the list of categories of health insurance.
- Health spending accounts HSA - Two questions were added to capture a private health plan’s deductible and whether the plan is associated with a Health Savings Account.
- Flexible spending accounts FSA - Three questions were added to capture the family’s participation in medical flexible spending accounts (medical or health).
- AHRQ is also planning an expert meeting follow-up this fall to assess the need for more comprehensive changes in MEPS HC content.

MEPS is also considering what additional questions and content might be tested and added to the Insurance Component. Interest centers on employer plans and offerings, firm size, actuarial value, stop loss policies, wellness programs, and additional detail on the characteristics of self insured plans and small employer anticipated exchange participation.

### **Healthcare Cost and Utilization Project (HCUP)**

The Healthcare Cost and Utilization Project (HCUP) provides data and analytics to track progress in health care quality, value, and outcomes. HCUP tracks these areas not only at the national level, but at the State and community levels as well. In addition, because of the size and robustness of the dataset, it can track progress in reducing disparities in each of these areas, and can track progress in care even for very infrequent conditions or procedures. Finally, HCUP has developed a modeling capacity that can test the impact of health care policy on outcomes in health care delivery across acute care settings.

Current and anticipated enhancements to HCUP will enhance the utility of the datasets for tracking ACA progress:

- More States: HCUP recently added Alaska and expects to add Mississippi in the near future.
- More sites: HCUP has been adding emergency department and ambulatory surgery data for more States, and also has begun to analyze data on observation stays.
- More clinical detail: HCUP has encouraged and facilitated development and improvement of Present on Admission (POA) data, laboratory values, and more recently pharmacy data. Greater availability of EHR data is anticipated as Health IT adoption increases.
- More timely information: HCUP has developed capacity for rapid-cycle estimates, using quarterly data from some States and modeling capacities made possible by a 20 year data history and new sophisticated algorithms.
- Information on readmissions and revisits: By working with States to facilitate development of patient identification methods, HCUP can now track readmissions, as well as other revisits to emergency departments and ambulatory surgery.
- More tools: Recent additions include a chronic conditions flag and procedure classes.

- More support for local tracking and public reporting: The MONAHRQ (My Own Network Powered by AHRQ) web-builder enables States and communities to mount their own websites using local discharge data and local Hospital Compare data for local analysis and public reporting. MONAHRQ tools will expand in the next few years.
- More modeling and simulation capacity: HCUP has begun to develop the infrastructure needed to not only track impact but predict potential impact. HCUP also has conducted studies of geographic variation in utilization and costs for all patients – data formerly available only for the Medicare fee-for-service population.

## **CENTERS FOR MEDICARE AND MEDICAID SERVICES**

### **Medicare Current Beneficiary Survey (MCBS)**

The Medicare Current Beneficiary Survey (MCBS) is a nationally representative stratified random sample of the total Medicare population, whether aged or disabled, living in the community or a facility, or served in managed care or fee-for-service. The central goals of the MCBS are to determine medical care expenditures and sources of payment for all services, and to trace processes over time, such as changes in health status, spending down to Medicaid eligibility, access and satisfaction, and the impacts of program changes.

Current capabilities and recent ACA related enhancements to the MCBS include:

- The ability to capture changes to premiums, cost-sharing, including premium tax credits and cost-sharing reductions, temporary adjustment to the calculation of Part B premiums, and other changes.
- The ability to capture changes to Part D coverage gap closure, catastrophic limit reduction and discounts.
- Utilization and beneficiary knowledge of Medicare-covered preventive services, and
- Enhanced collection of data necessary for analysis and reporting on health disparities, including the recently adopted HHS data collection standards for race, ethnicity, English proficiency/primary language and disability.

CMS is currently evaluating the feasibility of survey supplements that could provide targeted information (i.e., specific population, specific questions) in a short turnaround cycle.

Incorporation of new program flags/beneficiary identifiers and other ACA-related administrative data is also being considered to help highlight program populations in the survey sample and enhance the survey research files produced. Potential flags for beneficiaries treated by an ACO or enrolled in national demonstrations and pilots are being investigated.

### **Medicare Health Outcomes Survey (HOS)**

The Medicare Health Outcomes Survey (HOS) is used by CMS to measure patient-based health outcomes in the Medicare Advantage population. The goal of the survey is to gather valid, reliable, and clinically meaningful health status data on the Medicare Advantage population for use in quality improvement activities, pay for performance, program oversight, public reporting, improving health, and health services research.

With respect to recent enhancements, the HOS includes Medicare Advantage Payment and Performance Measurement – Six of the survey measures are currently used in determining quality bonus payments for Medicare Advantage Organizations.

### **Consumer Assessment of Healthcare Providers and Systems (CAHPS) Surveys**

The CAHPS survey efforts collect and report objective information from the perspective of consumers about their experiences and satisfaction with their plans and providers to help consumers choose and CMS assess performance. Currently, CAHPS surveys focus on health plans, drug plans, fee-for-service in a geographic area, hospitals, and home health agencies. To monitor the impact of health reform, CAHPS measures will be used to assess patient satisfaction and perceptions of care and quality.

### **Medicare Consumer Assessment of Healthcare Providers and Systems (Medicare CAHPS)**

The Medicare CAHPS surveys collect, analyze, and report data that measure beneficiaries' perceptions of care and services received through Medicare Part C and Part D as well as original Medicare Fee-For-Service programs. Consumer evaluations of health care measure important aspects of patient experience that often cannot be assessed by other means. Medicare CAHPS measures health plan performance in several specific areas including getting needed care, getting care quickly, doctor communication, health plan customer services, getting needed prescription drugs, getting information from plans, and enrollee ratings of health and prescription drug plans. Medicare CAHPS also obtains information on coordination of care issues.

Potential enhancements include implementation of the new HHS data standards necessary for analysis and reporting on health disparities such as differences in plan performance reported by enrollees with differing racial and ethnic characteristics. Also under consideration are new measures based on care coordination, including how often personal doctors have enrollees' medical records or other information about their care during scheduled appointments.

### **Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)**

HCAHPS is a national, standardized, publicly reported survey of patients' experience of hospital care. HCAHPS data will be a key part of Hospital Value-Based Purchasing (VBP) in October 2012. Currently, over 3,800 hospitals publicly report HCAHPS scores on the Hospital Compare Web site. Eight HCAHPS measures are used to construct the Patient Experience of Care domain in Hospital VBP, which will account for 30 percent of hospitals' Total Performance Score. Since its inception HCAHPS has contained 27 items. However in 2012 CMS will add five new items: three about the transition to post-hospital care, and two about the patient's condition.

With respect to current capabilities and recent enhancements, HCAHPS data will be part of Hospital VBP that begins in FY 2013 as part of the Affordable Care Act. In addition, three survey items related to care transitions and two items related to admission through emergency rooms and mental health status are planned additions to the survey over the next year.

### **Home Health Care Consumer Assessment of Healthcare Providers and Systems (HHCAHPS)**

The HHCAHPS survey supports the goals of health reform concerning transparency, advancing quality in home health care, and providing information to the public about a vastly expanding industry so that information can be used in a manageable format. The HHCAHPS survey is part of a family of CAHPS surveys that asks patients to report on and rate their experiences with health care. The HHCAHPS survey presents home health patients with a set of standardized questions about their home health care providers and about the quality of their home health care. Prior to this survey, there was no national standard for collecting information about patient experiences that would enable valid comparisons across all home health agencies (HHAs).

### **Federal Agency Collaboration**

In addition to the enhancements to the HHS sponsored surveys, the Department is working closely with experts from the Census Bureau on the planning, design and testing of additional health reform related questions that may be considered for inclusion in Census surveys, such as the American Community Survey and the Current Population Survey as well as HHS surveys. These federal collaborations provide the opportunity to identify and coordinate survey and system enhancements to data collection activities, and maximize the content and quality of information collected to monitor health reform.

### **Conclusion**

Although many HHS data systems represent the state of the art in their class and are continually improving to meet emerging data needs, new challenges are placing increasing demands on these resources. New data needs are arising, significant gaps exist, pressures for improved timeliness are mounting, and costs are increasing. At the same time, new administrative data systems associated with health reform and the widespread adoption of EHR systems and electronic information exchange can provide a wealth of new data sources. HHS initiatives are underway to 1) improve the quality, timeliness and utility of our data collection systems, and 2) make HHS data more easily available for analysis and innovative uses to improve health and health care.