A PLAN FOR IMPLEMENTING A STATEWIDE HEALTH CARE COST AND QUALITY REPORTING WEBSITE IN NEW MEXICO

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National Association of Health Data Organizations

A Plan for Implementing a Statewide Health Care Cost and Quality Reporting Website in New Mexico

The demand for consumer health care cost and quality information is growing, especially as consumers assume a greater burden of their health costs. With the enactment of an amendment to the New Mexico Health Information System (HIS) SJC/SB 323 & 474[1], the State of New Mexico joins a growing number of other states establishing consumer-facing websites in order to provide citizens with system-wide information about health care pricing and quality. This type of information, especially in user-friendly formats, is a relatively new undertaking for the New Mexico health care industry and it poses a set of unique challenges, both technical and political.

On the technical side, obtaining access to comprehensive data sources is a major hurdle. Health care cost and other information has historically been considered proprietary and not generally available to the consuming public. In addition, the fragmented health care delivery system contributes to the lack of standardized data and information, challenging cross-system analysis and comparisons. On the political side, there may be resistance to publication of health care system comparative performance information due in part to data deficiencies, but also because cross-system public reporting of cost and quality is a relatively new and rapidly evolving undertaking. And finally, even if these obstacles are overcome, consumers may not use a cost and quality website once it goes "live", because of lack of awareness of the site and/or the site itself is not consumer-friendly or because the site has limited functionality.

Despite the challenges, consumer websites are developing in both the private and public sectors in attempts to assist consumers in their health care decisions. Consumer uptake of these sites has been mixed, but the more consumers can access price and quality information over time, the more it is likely their use will increase[2].

A consumer cost and quality website is comprised of three ingredients: data sources, meaningful measures, and usable tools for dissemination of information. New Mexico is seeking practical approaches based on other public consumer transparency website initiatives, and is adapting these to New Mexico's reporting environment and budget. This report, submitted by the National Association of Health Data Organizations (NAHDO), lays out a framework for initial development and future expansion based on lessons learned across state reporting initiatives.

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[1]

http://www.sos.state.nm.us/uploads/files/SB323_474-CH121-2015.pdf

[2] Robert Wood Johnson Foundation Webinar, Consumer Reports presentation, May 11, 2017.

Information System Act Advisory Committee and to provide technical assistance as they explored options and considerations for publishing data to the public, as required by law. Understanding the important role of publicly-available information, the New Mexico Legislature revised the Health Information System Act in 2015, directing the Department of Health to establish a Health Information System (HIS) Advisory Committee to explore approaches for posting cost and quality measures on frequently-used health care services and procedures.[3]

ABOUT NAHDO

The National Association of Health Data Organizations (NAHDO) is a national non-profit educational association dedicated to improving health care through the collection, analysis, and dissemination of health care data. Since 1986, NAHDO has advocated for the public availability of data, balancing the need for privacy protections with the utility and accessibility of data to serve the public good. NAHDO members include state and private health data organizations that maintain statewide hospital discharge data reporting systems and/or All-Payer Claims Databases (APCDs) and federal, academic, and corporate organizations that support and use information from these statewide initiatives. These data support important information for payment and delivery reforms, transparency tools and reports, and population health and research. NAHDO has worked with many states on data collection, analytic, and dissemination projects, providing technical assistance and support for their activities. In 2007, NAHDO formed a joint collaboration with the University of New Hampshire's Institute for Health Policy and Practice to establish the All Payer Claims Database Council and the APCD Learning Network.

ABOUT THE NM HEALTH INFORMATION SYSTEMS ADVISORY COMMITTEE

All of the NM website decisions are made in context of the current reporting environment in New Mexico and reflect the realities of budget and other constraints. The HIS Act Advisory Committee, appointed by the secretary of health, is comprised of stakeholders from various constituencies. The Committee's role is to advise the New Mexico Department of Health in carrying out the provisions of the Health Information System Act, which includes approaches for the posting of information for public access, including cost and quality measures of frequently used health care services and procedures by January 1, 2018.

The advisory committee (Appendix X) has a mandate to[4]:

   (1) review and recommend to the department methods for the effective dissemination of health information reports, to include the availability of reports that would be of interest to the public;
   (2) review health information reports and recommend amendments for the purpose of rendering reports most useful and understandable to a lay audience;
   (3) recommend reports that will address public concerns regarding health information and access to health care; and

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[3] http://164.64.110.239/nmregister/xxvii/xxvii03/7.1.28.htm
[4] http://164.64.110.239/nmregister/xxvii/xxvii03/7.1.28.htm

(4) advise the department in carrying out the provisions of the Health Information System Act.

During the first committee meeting the overall goal of empowering individual consumers and legislators with meaningful information on healthcare costs and quality was discussed as well as a number of associated actions committee members felt were critical to achieving their goal. They focused on providing critical information on cost and quality in a timely manner, which means they needed to keep plans and actions transparent, and to provide opportunities for input by consumers, payers, and providers, and to initially use existing data sources. These decisions and directions could quickly drive the development of a "good enough" start in representing healthcare cost and quality information while also looking for funding for future new sources of data (APCD).

During seven meetings between June 2016 and May 2017[5], the HIS deliberated various approaches to public reporting and considerations that ranged from data sources, cost and quality measures, model websites, and constraints challenging health information initiatives. HIS discussions laid out principles for a future reporting initiative in New Mexico:

- Use existing data where possible
- Cost and quality data are both important
- Prioritization of "shoppable" procedures
- Empowerment of individual consumers through publicly-available information

It is important to recognize that New Mexico, like many states, faces a series of decisions related to a transparency website launch and, like other states, New Mexico has a limited budget for website development and maintenance. The following sections discuss the New Mexico website framework in light of various best practices around data sources, website content, and website display.

PROJECT METHODOLOGY

NAHDO provided consultation to the New Mexico Department of Health (NM DOH) to guide the initial approaches for consumer website development, based on legislative mandate and stakeholder priorities. NAHDO and NM DOH convened bi-weekly web meetings during the project period. The NAHDO team reviewed the materials generated by the Health Information Systems (HIS) Advisory Committee, interviewed staff at the NM DOH charged with implementation of the website, and reviewed approaches used by other states' public consumer websites around key website components: data sources, website content, and website display. This report summarizes the options considered and approaches selected by the NM DOH and stakeholders in context of the current New Mexico health information environment.

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[5] https://nmhealth.org/about/erd/hsep/hidd/

What data sources are available in NM?

Before advising the New Mexico stakeholders about the content and structure of the New Mexico consumer website, the NAHDO team first had to gain understanding as to the data sources currently available as well as the potential for expansion to new sources of data. A significant amount of time was directed toward a discussion and inventory of data sources typically supporting public websites.

What information will be included in a consumer website?

After understanding data sources and reporting environment in New Mexico, the NAHDO team was able to provide guidance on a range of measure options for the state website based on national and state reporting trends. We reviewed a wide range of options with the NM DOH. It became clear early on that New Mexico stakeholders were interested in two of the top public transparency websites NAHDO suggested as models for the New Mexico consumer website:

- https://nhhealthcost.nh.gov
- http://www.comparemaine.org

The NH Health Cost website contains a cost estimator for common conditions as well as separate query functions for quality. The Compare Maine website includes measures of hospital quality alongside the pricing information (side-by-side comparisons). Much of NAHDO's discussions around measures and content for the website centered on options for using existing data and potential approaches to filling these data gaps in the short-term and long-term, including use of hospital discharge data and public-domain measures such as the Agency for Healthcare Research and Quality's (AHRQ) Quality Indicators. An inventory of potential measures was compiled and entered into a spreadsheet for review by the NM DOH. During the course of this project, two developments arose that shaped initial decisions for the New Mexico website: 1) Access to the Human Services Department (HSD) Medicaid claims data warehouse and 2) Publication of "shoppable" consumer conditions in a Health Affairs article in which Aetna commercial data were used to produce these measures (discussed below).

Website implementation issues

NAHDO reviewed the top ten cost and quality websites and identified key best practices for website development. New Mexico will need to adapt these state practices according to the current realities of timing and budget constraints. The NM DOH will be required to use the NM DOH IT Template display for background and color, which has implications for branding of the website. The acquisition of the NH Health Cost website programming code and technical documentation during the project period provided the NM DOH an opportunity to test the feasibility of adapting another state's web platform as a cost-effective solution. Modifications will be essential to accommodate New Mexico's data source decisions and IT environment.

Summary of New Mexico's Website Approach

Based on exploration of the New Hampshire and Maine sites and a survey of the HIS Act Advisory Committee, the desired attributes of a New Mexico website were identified and reported to the NM DOH:

- Easy to use/User friendly;
- Quality and cost data are connected;
- The website's overall appearance is engaging;
- Good cost estimation, including additional parameters available for calculating a better cost estimate;
- Search functions that are useful;
- A site tutorial is provided; and
- The website appeals to a broad audience.

These attributes desired by the committee are in line with known best practices in public transparency reporting experiences in Maine, New Hampshire, and Vermont.

Because of the short implementation timeline for a website, and the lack of funding, it became clear that the NM DOH would not rely on an outside vendor, but instead would develop the website in-house utilizing existing public data sources to populate information and measures.

Data Source Decisions

The following public data sources were identified as potential candidates for populating measures in a consumer-facing website.

- New Mexico Hospital Inpatient Discharge Data (HIDD)
- Medicaid Claims Data/Human Services Data Warehouse
- Medicare Administrative Data
- CMS Hospital Compare Measures
- Hospital Consumer Assessment of Healthcare Providers and Systems) (HCAHPS)[©]

The main challenge that presented was the lack of system-wide claims data to produce consumer cost measures. The New Hampshire and Maine websites are based on All-Payer Claims Database systems (APCDs), but New Mexico does not have a statewide APCD; therefore, Medicaid claims data will be used for cost information on the initial website.

Website Content and Measures Decisions

In addition to the CMS and hospital measures, another measurement option arose during this project. During the course of these discussions, there was attention called to the Health Affairs article, "Examining A

Health Care Price Transparency Tool: Who Uses It, And How They Shop For Care",[6] highlighting a study of 600,000 Aetna members with high deductible plans. Of the 20 "shoppable" conditions and procedures studied, the NM DOH selected nine for incorporation into the initial website, listed below with their CPT codes:

- Colonoscopy (CPT code: 45378)
- Mammogram (CPT codes: 77057, G0202)
- Upper Gastrointestinal Endoscopy (CPT code: 43235)
- Vaginal Delivery (CPT codes: 59400, 59409, 59410, 59610, 59612, 59614)
- Cesarean Delivery (CPT codes: 59510, 59514, 59515, 59618, 59620, 59622)
- Vasectomy in a Facility (CPT code: 55250)
- MRI of lower extremity (knee) without dye (CPT code: 73721)
- MRI of lower back without dye (CPT code: 72148)
- Sleep Study (CPT code: 95810)

These nine measures were selected as cost measures for the initial website; the procedures will be displayed by average Medicaid payment by hospital facility. Because the HIS prioritized the publication of facility-level cost and quality measures together, the website will incorporate the CMS Hospital Compare and Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) alongside the Medicaid average payment data. The shoppable conditions of interest tend to be outpatient procedures or conditions (such as maternity) where patient factors (such as age or health status) are less influential to outcomes.

However, blending of these two data sources will require explanations about the different sources and advising caution in interpreting the results.

Website Implementation Decisions
The NM DOH will develop the NM Healthcare Cost and Quality Reporting website (HCQR) in-house while the feasibility of adapting the NH Health Cost Website is being explored.

Given these decisions and drawing on lessons learned in other state reporting initiatives, NAHDO proposes a framework for establishing and maintaining a cost and quality reporting website in New Mexico.

NEW MEXICO DATA SOURCES
Data sources are the fuel that powers any website. Without interesting and relevant data, all of the bells and whistles of technology are almost meaningless if the selected measures cannot be produced. Establishing a new health reporting system is time-consuming and costly, making existing data sources an attractive option in many states because the infrastructure for collection and aggregation are in place.

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[6] Health Affairs, April 2016 35:4662-670; doi:10.1377/hlthaff.2015.0746

The following data sources contain health care utilization, payment, and/or quality information, are available from state or federal agencies at minimal cost, and have been used by other state consumer websites. These health care data sets are currently available in New Mexico:

New Mexico Hospital Inpatient Discharge Data (HIDD)

New Mexico is one of 48 states that collect statewide inpatient hospital discharge data. Hospital discharge data systems capture record-level information on every patient discharge from an inpatient stay in non-federal acute-care hospitals. New Mexico has collected hospital discharge data in some form since the mid-1990s—first through the New Mexico Health Policy Commission—and since 2012, through the NM DOH. Thirty-six acute care and 16 specialty facilities report 268 data elements quarterly to the NM DOH. This population-based data set includes longitudinal and statewide information on all patients treated in inpatient facilities, regardless of payer. Hospital discharge databases are a recognized and cost-effective source of data for market, policy, and research applications. Because they contain detailed, record level information on all inpatient encounters, these population-based data sets support a large range of uses and serve diverse audiences. The limitations of hospital discharge data are primarily that outpatient services are not included and the data include charges, not payments. Despite these limitations, hospital data provide a foundation for many reporting initiatives, especially about access and patterns of care across the system.

Medicaid/HSD Data Warehouse

Medicaid administrative data are a potentially rich source of information about the health care use and health status of a vulnerable population. This may be especially true in the state of New Mexico. Medicaid modernization in the form of Centennial Care provides coverage for about 40 percent of New Mexico's population, making this a potentially rich source of claims and administrative data for measuring and monitoring population health and the performance of the health care system. In the absence of a statewide All-Payer Claims Database (APCD) which incorporates other public and private payer files, Medicaid is a data source that could serve as a platform for future expansion to commercial claims because it contains similar data elements and files. While many states are implementing claims reporting systems from both private and public payers, New Mexico does not have in place a system-wide reporting initiative, making claims from public payers a viable option. New Mexico's Medicaid data alone provide important information about health care delivery in the state. State expenditures on publicly-funded health care during state fiscal year 2015 total $1.7 billion—almost one-third of the total state budget of $6.2 billion.

Medicare claims and beneficiary administrative data

States can acquire Medicare data from the Centers for Medicare and Medicaid Services (CMS) through a Qualified Entity process or through the State Agency Release process. The State Agency Release approach requires the state agency to provide data security assurances and meet requirements stipulated in the

application. The data can be used for multiple purposes and under multiple funding sources, as long as the data is used at the direction of the state and the funding originates with the state. Many states have submitted and received Medicare administrative data and NM DOH is encouraged to draw on lessons learned from these states. The DOH can select to opt-in to data sharing, in which the data can be reused by other state agencies and for additional research purposes or select a more restrictive opt-out arrangement.

Information about other state Medicare analytic activities is available through NAHDO and the APCD Council's Learning Network (www.apcdcouncil.org). The request process and documentation can be found on the Research Data Assistance Center (ResDAC)

https://www.resdac.org/sites/resdac.umn.edu/files/State%20Data%20Requests%20Memo.pdf

NEW MEXICO CONSUMER WEBSITE APPROACHES AND DISCUSSION

The NM HCQR website will publish facility-level cost and quality metrics side-by-side using existing public data sources. Cost methods reviewed with the NM DOH included the following measures:

Cost Measures

- Average payment amount from claims data: Claims data provide information about actual payments —both patient liability and provider payment—and are increasingly becoming a source of cost data for policy and consumer price information. A growing number of states are aggregating claims including physician, facility and ancillary services across all health care settings, yielding large sample sizes and powerful information about defined populations which was previously difficult to capture and use. States without an established APCD (claims reporting initiative), like New Mexico, are exploring using Medicaid claims as an alternative source of cost information in the form of average payment amount for a procedure or condition.

- Hospital Total Charges: Cost-to-Charge Ratio (CCR)[7] is based on the charge associated with a hospital stay or procedure. This methodology can be used as a proxy for consumer price information. Because true cost of hospital care varies considerably from charges, efforts were made to develop a method for ascertaining a good estimate of the cost of care. These efforts to improve cost reporting were undertaken by AHRQ. Dr. Bernard Friedman's research led to the development of the CCR as a model for users of hospital discharge data.

The HIS rejected the reporting of facility-level comparisons using the CCR methodology, leaving the next viable option of Medicaid claims data for initial website launch. Although system-wide claims data would be

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[7] Cost-to-Charge Ratio, https://www.hcup-us.ahrq.gov/db/state/costtocharge.jsp

the ideal, starting with Medicaid claims and other public data sources, such as Medicare claims, can serve to lay the foundation for future expansions to broader data, such as commercial claims.

New Mexico will begin with facility-level measures which are supported by the available claims and measures that will be adopted in the NM HCQR website. Medicaid claims data, through the Human Services Department (HSD), was obtained by the NM DOH during the course of the project period and will serve as the source of payment data in New Mexico, even though it will pose unique challenges.

For the initial website launch, the NM DOH will use record-level Medicaid data for the previously described nin "shoppable" health care procedures and conditions:

- Colonoscopy
- Mammogram
- Upper Gastrointestinal Endoscopy
- Vaginal Delivery
- Cesarean Delivery
- Vasectomy in a Facility
- MRI of lower extremity (knee) without dye
- MRI of lower back without dye
- Sleep Study

Additional Variables/Parameters that are included in the data extract include the data elements below:
- Provider Type (most likely Medicaid)
- Insurance plan information
-         Deductible amount (if applicable)
-         Co-pay amount/percent (if applicable)
- Facility Name (where procedure took place)
- Procedure codes
- Patient zip-code
- Patient county of residence
- Patient Age
- Patient Sex

The DOH will have to work closely with HSD to obtain, validate, and create the analytic files for the consumer website. The data request specifies that an indicator variable be created for each healthcare procedure/condition in the preferred format (CSV document or something similar).

NAHDO Recommendations:

- There should also be a request for a table of measures (procedures/conditions) with frequency counts for each that can be used as a reference table for reporting.
- Expansion to commercial claims information should be considered after initial website implementation (see text box below).

Considerations for Expanding to Commercial Claims Data for Shoppable Conditions

After the launch of the initial NM HCQR website, the NM DOH may want to expand to commercial data using a voluntary reporting model. This approach is used in some states without a reporting mandate, with mixed success. NAHDO recommends that the NM DOH issue a data request to its large commercial carriers, using the specifications for the Medicaid data, for the nine target procedures used in the Medicaid data extract, including total payment (and volume) across all commercial lines of business, for the same time periods, as the Medicaid data. The initial request may also want to include facility and regional-level fields, but this more granular data request could be delayed to future submissions if there is resistance by the payers and providers for such reporting in the early stages of website development.

Because the data call is limited and very specific, there is less reporting burden on the carriers and the case for enhancement of the Medicaid payment data can be made to make the website more relevant for the broader audiences of health care consumers.

Once the commercial data is available, there are other considerations for publishing this information data to the website:

- Publish average across all plans of total spend/total volume for the commercial plans that submitted data.
- Post the commercial average with the Medicaid average for the same time period.

New Mexico could list the payers providing the data, but not at the plan level, to demonstrate that they are collaborating in this initiative. If any statistics are posted at the plan level, it is best to "blind" or mask the plan. For example, "Plan A median and average payment, Plan B median and average etc. **NAHDO does not recommend identification of plans in the early stages of voluntary and website reporting.** A good example of how a state can publish area-level pricing information without identifying health plans is the consumer website developed by the Virginia Health Information organization (www.vhi.org).

If plans refuse to provide this simple data request, that is informative for future planning and might require legislation.

Note: Interpret with caution—The measures were applied to Aetna's commercially-insured population. There are differences between commercially-insured and Medicaid populations. For example, the Medicaid population has certain subgroups, such as mothers and children, and elderly. Less frequent in the Medicaid data are single women under 65 without children and single men under 65 without children. In addition, low family income or lack of family income is associated with increased risk for chronic conditions, such as diabetes, and the population in Medicaid is low income putting them at much higher risk. The type and number of procedures may vary along with the population age, gender and state of health. This could result in small numbers in a county, or other problematic data issues.

Medicaid data may eventually support the publication of data at the clinical or physician-levels, but attribution at granular levels will be difficult in the early stages of consumer reporting. Strengths and challenges related to the use of Medicaid data in consumer reporting are highlighted in the table below:

Positive	Challenge
Broad coverage: 40% of New Mexico's population is covered by Centennial Care	The Medicaid population and its health care use may not be representative of the commercially-insured population
State spending on health care in 2015 totaled $1.7 billion, the largest category after education	The majority of the Medicaid population is enrolled in a capitated program and reimbursement is based on Per Member Per Month (MPM) rates
Bending the cost curve in Medicaid and improving quality could set the stage for broader impact	Medicaid payments for procedures may not reflect the commercially-insured costs
HSD has access to benefit design components that may not be available for commercial carriers	Medicaid benefit design may not reflect commercial plan designs

Table 1

Quality Measures

Incorporating quality measures in a consumer website is done to promote the concept of "value", not just cost comparisons. Like cost measures, quality measures are dependent on data availability and methods, such as risk adjustment when comparing provider performance. Quality measurement initiatives typically aggregate data to address aspects of health care quality, such as overuse, underuse, misuse, and patient perception. There are several different types of Quality Measures, including: outcome, process, and structural measures that can be selected based on data source and priorities.

NAHDO reviewed existing measure sets that New Mexico should consider for their public reporting initiative. The following measures are in common use by public and private entities throughout the country and are tools for generating cost-effective, comparable measures.

The AHRQ Quality Indicators (QIs)[8] include three groups of non-proprietary, publicly available measures for standardized quality reporting from hospital discharge data: Prevention Quality Indicators (PQIs), Inpatient Quality Indicators

> ### *Qualities That Matter*
>
> *Few people who recently had a joint replacement or women who recently gave birth are aware that hospitals vary on each of the clinical qualities.*
>
> *Few people are aware that doctors' prices vary or that hospitals' prices vary for diabetes care, joint replacement or maternity care.*
>
> *Most people across all three groups say high prices are not a sign of better-quality care*.
>
> https://www.publicagenda.org/pages/qualities-that-matter

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[8] AHRQ Quality Indicators: https://www.qualityindicators.ahrq.gov/

(IQIs), Patient Safety Indicators (PSIs), and Pediatric Quality Indicators (PQIs) that include measures of health care access and quality, including adverse events linked to delivery of care.

CMS Quality Reporting: CMS has a comprehensive quality strategy and has a wide range of quality measures for various health care settings. These measures, reported to CMS under various quality reporting programs such as the Hospital Compare and the Hospital Consumer Assessment of Healthcare Providers and Systems survey (HCAHPS), are publicly available from CMS for download.

- **Hospital Compare:** the Center for Medicare and Medicaid Services (CMS) Hospital Compare.[9] Hospital Compare compiles information about the quality of care at over 4,000 Medicare-certified hospitals, including over 130 Veterans Administration (VA) medical centers, across the country. It summarizes up to 57 quality measures across seven areas of quality into a single "star rating" for each hospital. Hospitals report data to CMS through the Hospital Inpatient Quality Reporting (IQR) Program. The measures used can be grouped into:

    - Timely and Effective Care Measures (process measures)

    - Outcome Measures of Complications, Deaths, Readmissions (Patient Safety Indicators, Hospital-acquired Infections), Readmissions/Mortality measures.

- **Hospital Consumer Assessment of Healthcare Providers and Systems Survey (HCAHPS)**: These measures are patient experience measures, the HCAHPS Survey,[10] also known as Hospital CAHPS®. CMS and AHRQ developed the survey to provide a standardized survey instrument and data collection methodology for measuring patients' perspectives on hospital care. The HCAHPS Survey is administered to a random sample of patients continuously throughout the year. CMS cleans, adjusts and analyzes the data, then publicly reports the results. Hospital Compare currently reports results for: seven composite topics—communication (doctors, nurses), responsiveness of staff, pain management, medication communication, discharge information and care transition; two individual topics—cleanliness and quietness of the hospital; and two global topics—hospital rating, and willingness to recommend hospital. Hospital-level results are publicly reported on the Hospital Compare website four times a year. HCAHPS results are based on four quarters of data on a rolling basis. The HCAHPS survey is administered to a random sample of adult patients across medical conditions between 48 hours and 6 weeks after discharge from 4,000 hospitals participating and the survey is not restricted to Medicare beneficiaries.

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[9] https://www.medicare.gov/hospitalcompare/about/what-is-HOS.html

[10] Details about the data and the time periods of collection can be found at https://www.medicare.gov/hospitalcompare/Data/Data-Updated.html#https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/HospitalHCAHPS.html

- New Mexico will also include select quality measures, such as hospital infection rates, derived from the HIDD. At the time of writing this report, the exact measures had not yet been specified.

Proprietary Measures: Many analytic vendors have developed proprietary methods and measures which are incorporated into analytic dashboards or Business Intelligence tools. These can be costly to develop and maintain and the methodologies may not be transparent. Many states, like New Mexico, have a limited budget for analytic services, which can be significant. An option some states have selected is the adoption of publicly-available tools and measure sets, such as the AHRQ Quality Indicators, or CMS quality measures. The AHRQ Quality Indicator software can be downloaded and applied to local hospital data sets and the CMS has measure sets which can be downloaded from the CMS site. Both can be gleaned from public websites at no charge and both include standardized and validated methodology and measures.

Given the existing data sources available for New Mexico and the menu of potential measures, the following table highlights the relative utility of various data sources for cost and quality reporting, that NM DOH used in their decision making. The table underscores that fact that no one data source alone is sufficient for cost and quality reporting initiatives and therefore, most consumer websites will draw on multiple sources of data for their reporting purposes.

Relative Consumer Utility of Existing Data Sources in New Mexico

Data Source	Cost	Quality	Consumer Information	Comments
Hospital discharge	*	***	**	Total charges and hospital care only
Medicaid claims	*	**	*	Capitated and Medicaid payments may not reflect commercial insurance costs; Medicaid populations are at higher risk than commercial populations for chronic conditions
Medicare	**	***	**	Does not include <65 population
Hospital Compare/CMS	n/a	***	**	Good source of process/outcomes, hospitals only
HCAHPS	n/a	***	**	Patient perception, hospitals only
APCDs	***	*	***	Good source of system-wide payments, utilization
Health Information Exchanges (HIE) /clinical exchanges	varies	**	*	Variable governance models with different access policies across states, linkage provides legal/technical challenges

Table 2

    * Limited utility   ** Moderate utility   *** Strong utility

KEY DATA SOURCES POINTS:

For all record-level state data sources, such as Medicaid and hospital discharge, quality assurance, accuracy, and timeliness of the data and information is important to the overall credibility and relevance of the website. The following practices should be baked into the process:

- Build in time for data validation and cleaning. As discussed later, due to resource and funding constraints, the NM DOH will likely develop the website in-house using existing staff. These staff may have multiple tasks and projects in addition to the website activities. Because the website staff must work closely with Medicaid (or hospital data stewards) on quality assurance of the data and understanding its limitations, NAHDO recommends that one DOH staff person be assigned to the data management/quality assurance activities for purposes of continuity and consistency.

- When integrating two or more data sets into an analytic file, allow time for the cross-walk or mapping of the data sets into a uniform format. Medicare data sets are provided in a different format than Medicaid Management Information System (MMIS) structure.

- Medicare and Medicaid may have unique restrictions for data release and with any facility-level release, it is important to build in a review and validation period: one for Medicaid and a second for facility-level reporting prior to release.

THE FUTURE: ALL-PAYER CLAIMS DATABASES (APCDs)

In response to health care and payment reforms, a growing number of states are implementing All-Payer Claims Databases (APCDs). APCDs are databases, typically created by a state mandate, that generally include data derived from medical claims, pharmacy claims, eligibility files, provider (physician and facility) files, and dental claims from private and public payers.[11] APCDs can be used to describe the health care use of the insured population and, because they are based on claims reimbursement, the data provide information about actual payments – both patient liability and provider payment. Increasingly, states are aggregating claims including physician, facility and ancillary services across all health care settings, yielding large sample sizes and powerful information about defined populations which was previously difficult to capture and use.

New Mexico does not have an APCD reporting system in place, but is primed for establishing one if funding becomes available in the future. As a component of New Mexico's State Innovation Model (SIM) Design plan, there was broad stakeholder consensus on the need for a legislatively-mandated APCD system to be implemented by the DOH and under the authority of the Health Information Systems Act (HISA). During 2015, stakeholders came to consensus agreement on priority use cases as well as a staged or tiered approach

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[11] All-Payer Claims Database Development Manual, 2015, APCD Council (www.apcdcouncil.org)

to public reporting, beginning with regional and population-level results. If a system is established in the future, an additional priority "use case" to justify the collection of APCD data will be to enhance and expand the NM HCQR Website.

APCD Value Proposition

- States are implementing APCDs to facilitate health system transformation. System-wide claims data are helping states assess and target areas needing improvement and evaluate the effectiveness of state health reform and payment initiatives. Provide essential all-payer risk adjustment
- Longitudinal tracking of health data trends
- Identify cost drivers and strategies for containment
- Enable consumer decision support
- Evaluate access and barriers to care
- Measure the effect of reforms on a state's health care system
- Analyze population health trends and monitor public health indicators
- Identify areas for improvement in spending, disease management, and program effectiveness

Funding Options for APCDs

Public APCDs are typically funded by one or more of the following sources:

- General appropriations
- Fee assessments on public and private payers (health plans) and facilities
- Medicaid match
- Data sales

The Centers for Medicare and Medicaid Services (CMS) provides funding to state Medicaid programs through the Federal Funding Participation in which federal funds need to be matched by the state with non-federal dollars. Some states are obtaining (or exploring options for) a Medicaid match arrangement for their APCD implementation. Although CMS does not require state Medicaid agencies to participate in APCD initiatives, some states do require the sharing of Medicaid with other claims data. If such participation meets their Medicaid business needs, including planning for cost, efficiency, quality of care, system utilization, etc., federal matching funds are available for some of the costs associated with Medicaid agency participation in an all-payer claims database[12].

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[12] National Committee for Vital and Health Statistics APCD Hearing, CMS, Jessica Kahn, June 17, 2016 (https://www.ncvhs.hhs.gov/wp-content/uploads/2016/05/Panel-2-Jessica-Kahn-CMS-Witten-20160June17.pdf

There are various rates, depending on the scenarios, the first scenario being most relevant for New Mexico, as there is no current statewide APCD system.

- Scenario 1: If a state does not have an APCD, but would like to build one, the Medicaid program may be eligible for 90 percent matching funds for *their share* of the cost of that bill along with other entities that will be using the data and information. States taking this approach are addressing Medicaid's functional business requirements, creating analytic uses useful to the Medicaid program.

  - The state could, after it is built with the 90 percent Medicaid match, also receive a 75 cents on the dollar match for Medicaid's share of the ongoing maintenance and operations cost of the APCD. (technical and systems costs such as the data warehouse, analytics, and interfaces, but not rent or indirect costs and, not necessarily staff) This funding is substantial and is ongoing. There is not a cap. These funds do not expire.

- Scenario 2: When an APCD already exists, then Medicaid, if they decide they want to participate, can receive that 90 percent match to build their interface between their own state's claims and encounter data warehouse and the APCD. If there is one that is external, and they want to have a pipe to it to share their claims, CMS can pay for 90 percent of the cost for that interface. The state would have to match it 10 percent. That is just for that technical interface.

- Scenario 3: For states in which the Medicaid agency's ongoing participation in that APCD is not necessarily meeting some immediate required functional need, but the agency feels it is the "right thing to do" for many other reasons (good to have versus required to have), then the match is 50/50 for those ongoing maintenance and operations cost. In these states, the desired interface is something the state wants to be a part of and eliminates the need to build a duplicate infrastructure within their enterprise in order to do so.

States will need to connect with their Medicaid programs and CMS to define the goals and intended functions in order to find the right match rate for the right phase of work. Reviewing the quality of care and adherence to state policy guidelines of managed care contract plans is one example in which it is in the Medicaid program's interest to make sure that the APCD has all of the right claims because those commercial plans that are doing premium assistance for Medicaid enrollees, and overseeing the quality of care and access for the Medicaid population benefits Medicaid recipients.

The CMS has been really working with state Medicaid agencies on this idea of improving the quality of their claims and encounter data. There is now a standard data dictionary with clear guidelines on coding and mapping to improve Medicaid encounter data quality and timeliness.

Health Information Exchanges are another example of such an arrangement where CMS provides 90 percent of the approved funds for eligible activities that can be allocated to and benefit the Medicaid program and its beneficiaries. Layering clinical data and claims data together can provide a more full view of not just utilization and cost, but also impact of Medicaid coverage. A lot of states have been investing in this for a while. Where the APCD is not linked to a Health Information Exchange or is not able to layer in clinical data, the states might find that it cannot meet all of their needs, especially for those patients that cycle in and out of Medicaid and commercial payers.

Accessing these funds requires working with and through the state Medicaid program. Funding flows to the Medicaid program. The NM DOH is in a separate agency from Medicaid, so an inter-agency agreement may need to be in place to enable transfer of funds to the DOH.

CMS and state Medicaid programs follow a detailed and thorough planning and approval process in the form of Advanced Planning Documents (one for planning and one for implementation). Funding is not a grant or cooperative agreement providing funding up front. The Medicaid program has a schedule for applying for reimbursements and until those funds arrive at the agency, the state or program will need to have access to funds to cover the new activities and staffing that were approved.

> ### *Health Information Exchanges (HIEs)*
>
> Many states have developed statewide or regional Health Information Exchanges (HIEs) that contain patient clinical and demographic information. The HIE models vary by state and can be provider-based repositories (distributed model) or a centralized repository (consolidated model). While linkage of clinical HIE data with public data sources, such as hospital discharge data and APCDs, have generated interest, the technical and legal hurdles have limited these linkages. Many HIEs are private provider-based, and data structures and data elements are not standardized across the system. Linkage of HIE data with other data sources, such as clinical registries or public health and census data sources, have the potential to enhance existing data sources—but for consumer websites, these linkages have yet to become the norm.

MEDICAID MATCHING FUNDS—KEY POINTS

- States must match their share using non-federal funds.
- Accessing these funds involves working with and through the Medicaid program because funding flows to the Medicaid program. Inter-agency agreements will be necessary if funds are to be transferred to another agency (such as the NM DOH).
- Funding is on a reimbursement basis and is not funded like grants or cooperative agreements that provide funding up front.

- The Advance Planning Documents span two years and Implementation Advance Planning Documents are generally updated and submitted annually and funding requires regular reports to the CMS regional office.

Website Reporting

There has been much progress made in relation to publicly available measures for cost and quality, since the early attempts in the late 1980s and 1990s. A number of entities have funded both measure development activities and improvements in consumer reporting, including: the Centers for Medicare and Medicaid Services (CMS), the Robert Wood Johnson Foundation, and the Agency for Healthcare Research and Quality (AHRQ).

Healthcare measure development work has been standardized through the National Quality Forum, Joint Commission, and AHRQ. Measures are designed for the spectrum of data available and sometimes specific to the data type, whether hospital discharge data, physician-level claims and clinical data, APCD, or health care survey data. Rigorous validation efforts have improved the quality of the measurement, as has attention to data quality.

Staging in Public Reporting Initiatives
What we mean by "staging" is really scaling the granularity of comparative reporting, starting with aggregate or more global measures, such as area-level (rural/urban, regional, state) and progressing in later stages to reporting at a more granular level (facility first, then clinic or physician). This granular level reporting is the most difficult in terms of data readiness (physician identifiers) and attribution (patient to physician assignment).

In the early stages of many public reporting initiatives, there often is a tendency for states to report/do public comparisons at the area/regional level because there may be issues of data completeness or quality or provider resistance to facility performance information. As the reporting systems and the data evolve, states gain more confidence in their data, advance their analytic capabilities, and through close stakeholder relations they can build trust with their provider and stakeholder community.

NAHDO brought up the staged or tiered approach in which global measures, (area-level measures such as state, county, or health services areas (rural, urban)) are the starter measures. Area-level measures are technically less complex to produce, there are widely-available open-source validated measures (so are transparent to the public), and they highlight system variation. Variation in volume, price, and outcomes are important indicators of overuse, underuse, or misuse of the health care system and do not usually require risk adjustment (which is technically complex).

One example of area-level price information for select health care conditions and procedures can be found at the Virginia Health Information website (www.vhi.org). As the APCD system matures, states, like Maine and

Best-Practice Website Attributes

- Include cost data, based on a dollar amount that represents the total amount paid for a service by both consumer and insurers.
- Quality data, based on methodologically-sound measures that consumers care about (safety, effectiveness) with symbols that clearly differentiate good and poor performers. Nationally-accepted measures (versus locally-developed measures) are technically and politically easier to implement and defend, and they support benchmarking of results with state, regional, and national measures.
- Integration of cost and quality data is ideal and introduces the concept of "value". A recent study by Altarum (www.altarum.org) indicated that consumers who were surveyed found price + quality information on-line useful, but hard to find. A study by Public Agenda, "Still Searching: How People Use Health Care Price Information in the United States, New York State, Florida, Texas and New Hampshire ((https://www.publicagenda.org/files/publicagenda_stillsearching_2017.pdf) found that consumers survey do not think high cost necessarily equals high quality, which is counter to the anecdotal belief that higher cost is linked to better outcomes.
- Price variation across providers is a surprise for some consumers (and policy makers as well) and may be one of the most important contributions of any initial public reporting initiative. Price variation can be a motivator for consumers to pursue more information online; some consumers have high deductibles and will be bearing the cost of care until their deductible is fulfilled.

New Hampshire, will release data at the facility (and eventually group practice) levels and even integrate multiple data sources to publish cost and quality measures at the hospital level.

Since New Mexico will launch its initial website with facility-level reporting, we suggest some of the effective practices based on the ample lessons learned in other states, including those listed below. Public reporting of comparative health care data is a complex process, both technically and politically. Establishing clear procedures for the reporting initiative, from data intake through reporting, and making the decision process and reasoning clear and transparent goes a long way in building support and trust. NAHDO recommends that the NM DOH work closely with data suppliers (Medicaid, payers and providers) as well as all stakeholders when releasing any type of public performance report, and offers to share other state best practices in public reporting initiatives

- **Facility review period:** As stated earlier in this report, NAHDO recommends that a review and validation period be built into the website reporting process in which each facility is provided with an

opportunity to review their own measures before publication. This reduces the element of surprise and also can alert the DOH if there are errors in the underlying data.

- **Interpretation guidelines:** Cost plus quality metrics published together provide a more complete concept of "value" in health care, but requires careful wording to guide a user's interpretation. Different data sources and measures are designed to capture specific concepts. High patient satisfaction or high process measure scores may not correlate with high or low costs. High volume in some procedures is linked to better outcomes—but for other conditions, such as Cesarean Sections or back surgery it may indicate over-use and unnecessary care.

- **Document limitations:** The selection of the CMS Quality Measures is in line with choices made by other states, but the outcomes should be identified as Medicare outcomes, and information should be provided about differences in time periods between Medicare data and the other data sources used in the website. There should also be clear statements about the limitations of the data (age groups found in the data) as well as differences in interpretations of who is included and excluded in measure results, etc. It is useful to create examples of appropriate use and misuse. As stated several times in this report, without this added information, consumers could make decisions on a care provider that may be based on an inappropriate comparison.

Website Implementation

Online consumer websites are a viable option for disseminating health information to the public because they provide greater reach and can be updated frequently, unlike hardcopy print reports. However, establishing a consumer website can be costly and New Mexico, like other states, is under-resourced for website development. Vendor-based best-practice transparency websites can range from $400,000-$500,000 to start-up with ongoing maintenance and support costing about $200,000 annually.[13] The NM DOH will develop the website system in-house and is exploring the feasibility of adapting another state's website. As stated earlier, due to cost considerations the DOH will use its existing staff and technical resources to implement the health cost and quality website.

The key is to avoid making "the perfect be the enemy of the good" and build on lessons learned from other states and agencies that have embarked on this journey in launching and maintaining their public consumer websites. The expected "slow" consumer uptake of similar state sites will allow the DOH some "breathing room" to pilot test a prototype site, using an existing state's technology with Medicaid data as a foundation for expanded data and information as resources become available.

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[13] Consumer Information and Price Transparency Report, State of Vermont Green Mountain Care Board, Human Services Research Institute, and National Opinion Research Center, October 2015, pg vi

During the project period, the New Hampshire Department of Health and Human Services (HHS) has provided the SAS code and documentation to the NM DOH. The SAS code is based on the NH APCD database format. This state-to-state sharing of technology will save New Mexico a great deal of time and resources that otherwise would be dedicated to designing a system or contracting with a vendor to do the development. Perhaps the greatest challenge for adapting the New Hampshire system to New Mexico is that the system was developed for NH's APCD, which New Mexico does not yet have. There will need to be some technical programming to map the SAS code into the format of the New Mexico data sources (which at this point is only Medicaid claims data).

Ideally, state consumer websites should strive to adopt best-practice features to incorporate relevant information and ease of use. Attributes of high quality consumer websites include[14]:

- Using a framework to communicate elements of quality
- Presenting a message on the landing page that variations in quality have consequences
- Clearly presenting information on quality performance
- Providing additional resources for decision making, such as information on what to discuss with providers during a visit or links to other care planning tools
- Explaining how measurement values are generated
- Providing information about data timeliness
- Displaying cost and quality information side by side

Research has indicated that consumers are likely to move on within 20 seconds unless they are fully engaged by what they see.[15] A small percentage of the consumer population in states with transparency websites actually visit these sites—States report that they have difficulty attracting consumers to the healthcare transparency websites (they are not making significant use of the websites) especially related to quality, as consumers tend to believe that quality is the same across all entities. This low uptake of transparency sites is likely to change as health care reform takes hold and consumer liabilities increase. Recent research indicates that Americans are ready for value-based purchasing:

- The top frustration consumers have is not knowing the price before care, especially those who are uninsured and have a low income (Altarum.org)
- In a Public Agenda survey, over half of Americans tried to find price information before getting care. The other half who have not tried would like to[16].
- Sixty-nine percent of Americans say a website showing how much different doctors charge would help them with their health care spending.

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[14] Ibid, pg iv.
[15] Ibid, pg 15
[16] Robert Wood Johnson Foundation webinar, Price Transparency, Public Agenda Survey, May 11, 2017

- Large majorities of consumers thought it was important for state government to provide cost information.

However, consumers are not the only users of the website. Researchers, providers, and policy makers are likely to use the information. Layering the website design so that more complex information can be easily displayed for those looking for more detailed information is also important.

WEBSITE IMPLEMENTATION KEY POINTS

Budgetary and IT constraints will drive the look and feel of the NM HCQR website. It is important to keep in mind that visual appeal is only one factor and that ease of use and understandable information make up for glitzy media.[17] This means that there will need to be an emphasis on other attributes to capture the consumer's attention:

- Frequent updates and new content one or two time each year
- Include functionality such as search and cost estimator functions
- Easy navigation, minimal number clicks to get needed information
- Simple color scheme and rating icons need to be consistent
- Clearly present information on landing page about information being presented and how to use it.
- Present Cost and Quality side by side—explain that the data may not be the same source (footnote methodology)
- Other useful information for consumers such as questions to ask providers and other planning tools should be available
- Branding of the website along with outreach to consumers
- Websites should leverage search engine optimization or inclusion of features that ensure they appear on the first page of search engine results, which generates 92% of page views[18].

Given the in-house development model, it is important to recognize and attempt to apply best-practice lessons learned in other public website initiatives. NAHDO recommends the following practices for NM HCQR Website:

- Assign staff responsibilities and system oversight. While some aspects of website development such as privacy, IT services, and programming will likely be activities shared with other programs and/or assigned to staff who have other responsibilities, NAHDO recommends the assignment of one staff person dedicated to proactively managing and

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[17] Smashing Magazine, 7 Essential Guidelines for Functional Design, Dustin M. Wax, Aug. 2008
[18] Green Mountain Board Report, pg 82.

resolving data issues to provide consistency in the areas of data quality assurance for the website.

- Plan to convene at least one user focus group to test the site prior to public launch to identify glitches and identify possible cosmetic or functional enhancements that could be readily accommodated.

The NM HCQR website should provide information about the significance of the information and interpretation of specific measures, including avoiding misinterpretation of certain measures. NM DOH can look to other websites for modeling such content.

NM HCQR WEBSITE----VERSION 2 NAHDO RECOMMENDATIONS:

If we consider the NM HCQR Website, version 1, as a demonstration prototype and foundational platform for future measures and data, then NAHDO recommends the following expansion roadmap for future versions of the NM HCQR Website. These recommendations are based on existing data sources, publicly-available measures and tools, and have been implemented widely in many states across the country. It would be a cost-effective next expansion for New Mexico, perhaps for version 2.

Add a module for hospital comparisons. After launch, consider version 2 expansions to include additional hospitalization data measures (AHRQ Quality Indicators). The hospitalization data is already collected and provides an ongoing, longitudinal source of inpatient utilization in New Mexico. The Quality Indicators (QIs) have been tested, validated and used by many states for web-based information. The QIs have undergone National Quality Forum approval and are considered standardized measures. They are available for download, and widely used by state, federal, and industry entities. The Inpatient Quality Indicators (IQIs) include 28 provider-level indicators established by AHRQ that can be used with hospital inpatient discharge data to provide a perspective on quality. They are grouped into four measure sets: Prevention, Inpatient Quality, Patient Safety, and Pediatric Indicators and the code is available for download at no cost. The measure sets are standardized, and thus comparable for benchmarking against national, state, and regional results.

- Volume indicators are proxy, or indirect, measures of quality based on counts of admissions during which certain intensive, high-technology, or highly complex procedures were performed. They are based on evidence suggesting that hospitals performing more of these procedures may have better outcomes.
- Mortality indicators for inpatient procedures include procedures for which mortality has been shown to vary across institutions and for which there is evidence that high mortality may be associated with poorer quality of care.

- Mortality indicators for inpatient conditions include conditions for which mortality has been shown to vary substantially across institutions and for which evidence suggests that high mortality may be associated with deficiencies in the quality of care.
- Utilization indicators examine procedures whose use varies significantly across hospitals and for which questions have been raised about overuse, underuse, or misuse.

There is also a Toolkit for hospitals to help them use the AHRQ Quality Indicators for improving care in their facilities. https://www.ahrq.gov/professionals/systems/hospital/qitoolkit/index.html

Cancer Volume Data: Other measures that utilize existing hospital data, and have SAS code freely available, are a set of measures developed by the California Health Care Foundation using statewide California hospital data from the Office of Statewide Health Planning and Development (OSHPD). These measures have been clinically vetted and include measures for elective cancer-related procedures and could be produced and reported by DOH staff and displayed in a website module.

Commercial Claims Payment for Shoppable Conditions: As discussed in the text box, page 10, we propose an option for expanding cost measures beyond Medicaid. In the absence of a mandated reporting requirement for commercial claims, the NM DOH should request the voluntary reporting of average payment for the select nine "shoppable" conditions from commercial carriers. The reporting does not include personal health information and the limited data request does not pose a large reporting burden on the carriers.

Public Employee Claims: The DOH may want to explore the feasibility of, and options for, obtaining the state employee insurance administrative data to add to future versions of the NM HCQR Website. Many states are incorporating state/public employee data with their commercial data; a few states are beginning with Medicaid and public employee data. This data source does not require a legislative mandate, but it does require collaboration between state departments and agencies. NAHDO could provide examples of Memorandums of Agreement between other state agencies.

All-Payer Claims Database (APCD): New Mexico stakeholders generally support the development of APCD reporting and have provided input to a plan for statewide reporting that reflects priority information needs and use cases. This plan could serve as a roadmap for implementation once funding for such a system is made available. Figure 1 below illustrates the potential progression or stages that New Mexico might implement as the website evolves and as data sources become available.

The reporting trajectory is illustrated in the Figure below, where the initial website launch (Stage 1) incorporates facility-level cost and quality data, using Medicaid payment metrics alongside CMS hospital quality measures and provides a platform for expanding to new data types and measures in Stages 2 and 3.

New Mexico Healthcare Cost & Quality Reporting Website Stages

Stage 1: Initial Launch

Facility-level:

Cost: Avg Medicaid payment for 9 procedures

Quality: CMS Quality Measures + Hospital measures(s) from HIDD

Stage 2: Possible Expansions

Facility-level Reporting

Cost: add commercial plan avg payment for 9 procedures

Cost: add Medicare claims

Quality: Expand types of HIDD hospital measures (Cancer volume, AHRQ QIs)

Stage 3: Possible Expansion

Potential granular reporting at clinic levels

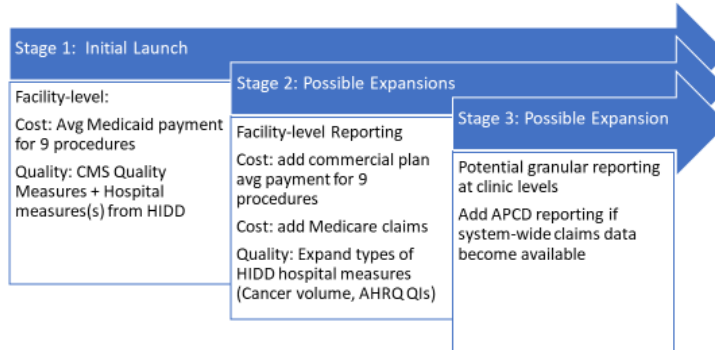Add APCD reporting if system-wide claims data become available

Figure 1

CONCLUSIONS

Any website, regardless of data source or design, requires a sustained effort. The NM DOH decisions for initial implementation of the NM HCQR Website is aligning with many best-practice principles in consumer website development, with clear options for cost-effective expansion and enhancements. Table X below highlights best-practice approaches and compares New Mexico's initial approach:

Best Practices	Approach	NM Specific Comments
Goals and Vision	Understand and address health care costs	Beginning with Medicaid claims data may not represent commercial prices/populations, but provides a platform for expansion
Website Approach	Hosting/development tailored to budget and agency requirements/resources	The NM DOH has the infrastructure and capacity for in-house development. Use of public tools and technologies and clear staff oversight responsibilities recommended.
Consumer Engagement	Consumer input pre- and post-launch	Recommendations have been made
Website Usefulness	Relevant information and ease of use	Information content and website functionality are expected to evolve as the NM HCQR system develops

Table 3

In summary, a consumer website is not a turn-key undertaking. It is a work-in-progress and an opportunity to bring the entire community together to shape a state-specific version of a website that meets the unique needs of the local stakeholders. Regardless of the difficulties, producing relevant measures and tools is an essential service for the public who are seeking information about their health care, especially related to the value of health care they receive. A recent Consumer Report study suggests that publishers of cost and

quality data should not underestimate the audience—"if data are relevant, consumers want more, not less"[19].

New Mexico faces unique challenges and the report proposes potential solutions to some of the common ones states often face. Whatever approach is taken in any state, including New Mexico, the key is to avoid making the "perfect be the enemy of the good"—a worn-out phrase often used, but especially pertinent to consumer health website development.

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[19] Robert Wood Johnson Foundation Price Transparency Webinar, May 11, 2017.