Sorting out the primary payer jumble: Part B—the US Experience

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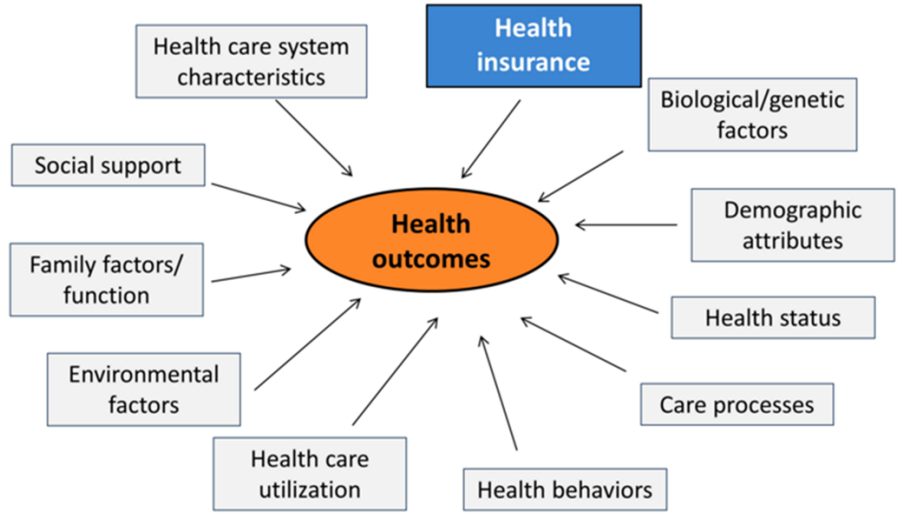
Presentation Objectives

- Provide a summary of issues surrounding the collection of Primary Payer
- Provide an assessment of the quality of the data currently captured in NAACCR's national dataset
- Propose methods for improving the collection of Primary Payer

Backgrou



Health insurance is one of many factors that contribute to health outcomes (figure adapted from Kaiser Family Foundation: What is Medicaid's Impact on Access to Care, Health Outcomes, and Quality of Care?

- NAACCR Item #630, Pri
  - required field, CoC
  - intended to document health insurance status
  - risk factor in studies evaluating quality or patterns of care, access to care, and health equity issues
- Increasing health insurance coverage (ACA)
  - may reduce overall burden of cancer and ameliorate longstanding health disparities
- Challenges related collection current diminish the value of Primary Payer at DX data
  - availability of data
  - uniformity and precision of collection

Background cont…

- Multiple NAACCR Taskforces (2014)
  - focused on issues surrounding the collection of Primary Payer at DX
    - 2014 NAACCR Concurrent Session
  - proposed a crosswalk between Primary Payer at DX and Public Health Payment Typology codes
- NPCR Data Quality Evaluation project (2010)
  - Castine Clerkin; re-abstraction (prostate & ovarian)
  - 60% of unknowns had known primary payer in chart
  - 7-28% changed insurance type between DX and TX
- Massachusetts (2013)
  - Pre- and post-insurance reform (insurance required 2006+ and free health care for 150% of pov)
    - Commonwealth care not a payer category—listed as private insurance even though paid by government
  - Re-abstraction & comparison to hospital discharge
    - strong agreement for known primary payer using general categories (all Medicare, all Medicaid, Private)

Data Collection Issues

- Information often missing in medical charts/facesheet
  - Information available is not always easily abstracted into current Primary Payer at DX codes
  - Lacking combo codes; name of provider versus provider type
- Proper coding requires knowledge of local and national insurance plan structures
  - constantly evolving & increasingly complicated
  - no uniform training programs and support services for abstractors
- Accurate coding can result in information loss
  - Example: Blue Cross has multiple plans
    - fee-for-service, managed care, and both public (Medicaid) and private insurance as well as "Obamacare" plans that may be public or private insurance.
- "Not insured" versus "Not insured, self-pay"
  - important distinction for research
    - "Not insured" = economically vulnerable patients
    - "Not insured, self-pay" patients are not low income
  - information available in the medical chart does not always delineate

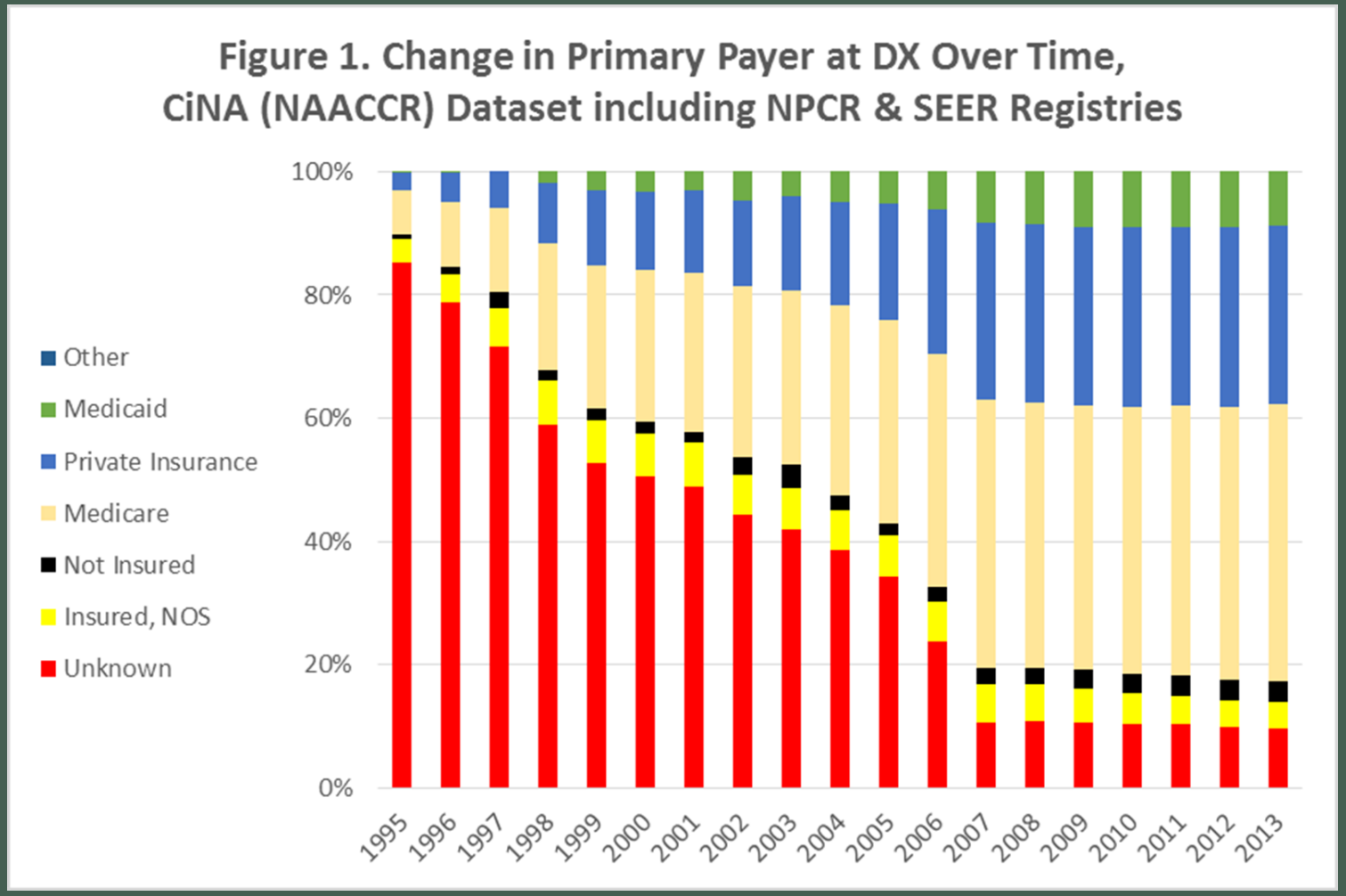
Data Collection Issues cont…

- Affordable Care Act (ACS) expected to increase
  - research may move from evaluating health outcomes among broad categories (i.e. Not insured, Private, Public) to evaluating specific plans or plan types (i.e. size, deductible limit)
  - Current codes do not currently capture potentially important details
  - Additional data sources may be useful
    - Public Health Payment Typology codes; but may not be universally or easily accessible
- Conflation of Primary Payer at DX and Primary Payer at TX
  - No national consolidation standards
    - not included in the NAACCR Data Item Consolidation Manual
    - Primary Payer at DX from a treating hospital may override data from a diagnosing-only hospital
      - Registrars often complete the field after a previously uninsured patient has been placed on insurance
    - FORDS allows the insurer at initial diagnosis **and/or** treatment to be coded in this field
  - can lead to biased research results
    - uninsured patients often quality for Medicaid after diagnosis
    - later stage at diagnosis for Medicaid patients when, in fact, many of the patients lacked insurance at diagnosis

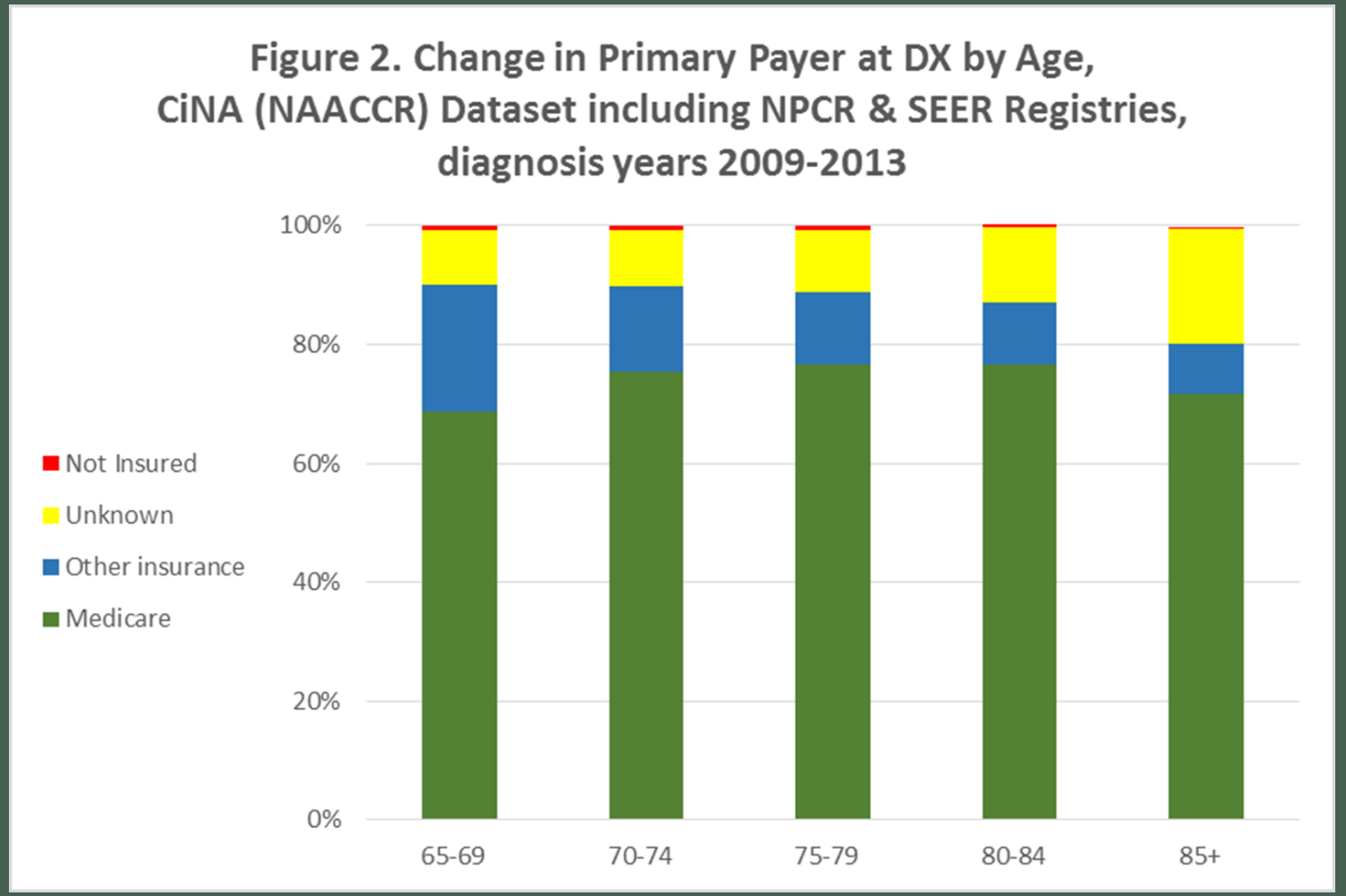
Data Quality Assessment

- Data
  - CiNA 1995-2013
  - Malignant cases
  - US registries
    - Removed states that do not report
- Assessment
  - Completeness
  - Age
  - AI/AN
    - CHSDA counties only
    - < 65 years

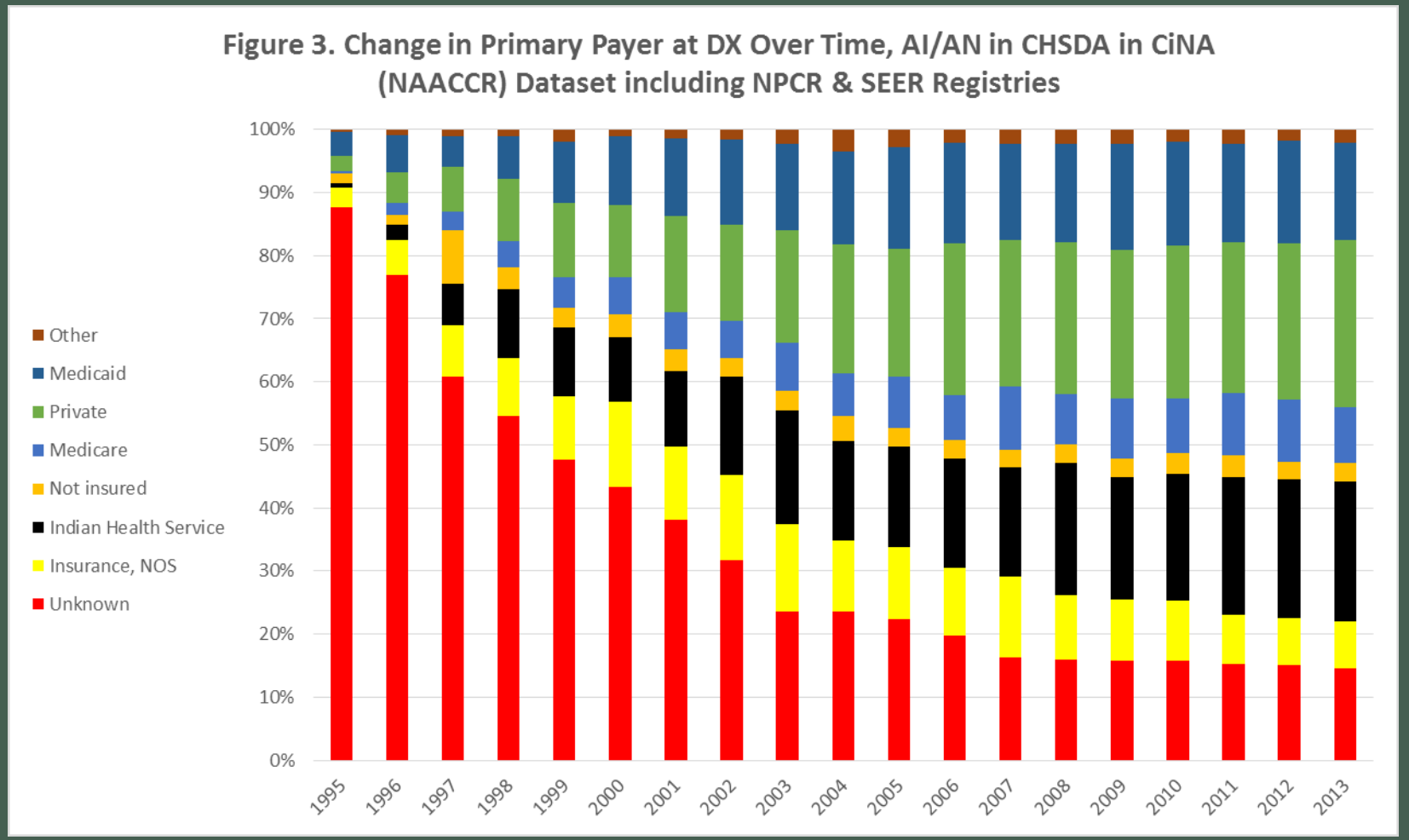
Data Quality



Data Quality



Data Quality



Data Quality

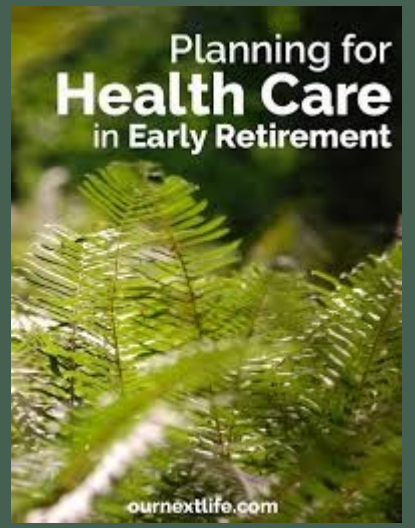
- Timing issues
- National Breast and Cervical Cancer Early Detection Program
  - Other federal and local programs
- Montana Example
  - 45% of the cases were coded to Medicaid
  - eligible for Medicaid **after** cancer diagnosis

Proposed Best Practices: Collection

- Promulgate importance of this field to abstractors
  - 60% unknowns had known payer in chart
- Consider collecting both DX and TX
  - won't conflate; researchers can group as needed
- Consider linking to Public Health Typology
  - Central Registry operation
  - won't lose data; researchers can group as needed
- Consider additional combo codes or multiple variables
  - for secondary & tertiary
  - Military with private or Medicare
  - won't lose data; researchers can group as needed
- Consolidation
  - use date versus report source or class of case, check vendor logic

Proposed Best Practices: Analysis

- Recode NBCCEDP to "No insurance" at DX based on annual link for analysis
- Recode "Unknown" and "No insurance" and "Insurance, NOS" for AI/AN in CHSDA counties to "IHS" for analysis
- Recode "Unknown" to "Medicare, NOS" age 67+ for analysis
  - for DCO cases, do not recode country of birth is known and non-US
- Requires providing supplemental information to researchers
  - Original and a recoded variable



Future Directions

- Revisit Crosswalk
- Write-up as unresolved issue in Volume 2
- Evaluate feasibility of Primary Payer at DX **and** at TX
  - 2 separate codes
- Research
  - uninsured historically important epidemiologic category for analysis
  - ACS coverage expansion
    - changes in coverage provide unique opportunities to assess the impact of access to care on cancer outcomes
    - Dr. Xuesong Han, NAACCReview http://news.naaccr.org/the-affordable-care-act-and-cancer-stage-at-diagnosis-among-young-adults/
- Evaluate NBCCEDP for additional states
- Evaluate by age, race, country of origin for additional states (unconsolidated)

Conclusions

- Completeness of Primary Payer at DX is improving
  - important accuracy issues remain
  - potential to bias research
- Unknown status often known
- National guidelines for recording and consolidating Primary Payer at DX are needed
  - Detailed coding instructions relating to timing are needed
    - Alternatively, one data item for Payer at DX and another for Payer at TX
  - Additional variables may warrant collection
    - DX vs TX, Primary Payer Typology versus NAACCR codes, additional combo codes
- As coverage increases, specific insurer characteristics may become important for patterns-of-care and health equity studies
  - Public Health Typology will facilitate more detailed information than current NAACCR codes

Thank you!

Any Questions?

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