Statewide All-Payer Claims Databases: Connecting the Dots for Transparency and System Reform

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Session Goals

- Provide an overview of APCDs
- APCD Approaches
- Review general uses of APCD data to date
- Discuss future issues

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Background

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National Association of Health Data Organizations and the All-Payer Claims Databases Council

NAHDO is a national non-profit membership association established in 1986 to promote the uniformity and availability of health care data for multiple uses and users

The University of New Hampshire's Institute for Health Policy and Practice established the Regional All Payer Health Information Council (NH, VT, ME, MA) for regional collaboration

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Our Work

- Early Stage Technical Assistance to States
- Shared Learning
- Catalyzing States to Achieve Mutual Goals

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Backdrop 2005-2013

- Increased Transparency Efforts (state, consumer, employer, etc.)
- Health Information Exchange (HITECH)
- Health Reform (PPACA)
- Payment Reform
  - Patient Centered Medical Home
  - Accountable Care Organizations

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Evolution of Health Data Programs

- Hospital discharge data are widely used for quality measurement, population health, market assessment and planning
- With health care reform initiatives and demand for transparency, critical information gaps become more evident:
  - Outpatient care
  - Pharmacy use
  - Physician/clinic level information
- APCDs fill gaps---and work in tandem with, but do not replace hospital data systems

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Paradigm Shift: State Data Silos to "Connecting Dots" Across the System

(or why are states building APCDs?)

- States recognize the need for robust, interconnected repositories of data.
- Despite funding constraints, states are investing in their information infrastructure:
  - Enhancement of existing health care data
  - Expansion to outpatient/all payer claims databases
- Essential infrastructure (it's not all about the IT):
  - Patient identifiers
  - Physician identifiers
  - Payment fields
  - Data analysts

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Definition of APCDs

- Databases, created by state mandate, that typically include data derived from *medical, pharmacy, and dental claims with eligibility and provider* files from private and public payers:
  - Insurance carriers (medical, dental, TPAs, PBMs)
  - Public payers (Medicaid, Medicare)

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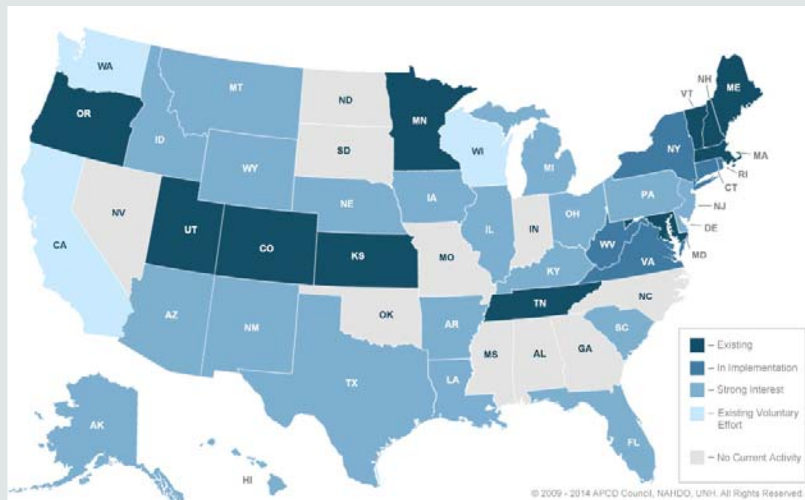
January 2014 State Progress Map



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APCD Development Decisions

- States consider a variety of factors about its APCD, including:
  - Business case
  - Authority, governance, and oversight
  - Funding
  - Who are the data submitters?
  - Technical solutions for aggregation and analysis
  - Data release

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Legislative Authorized APCD Governance Structures (10/12)

State	State Health Data Organization	State Health Department	State Insurance Department	Governor's Office	Designated 501(c)(3)	Aligned With HIX Funding	Aligned With Medicaid Funding
Colorado							
Connecticut							
Kansas							
Maine							
Maryland							
Massachusetts							
Minnesota							
New Hampshire							
New York							
Oregon							
Rhode Island							
Tennessee							
Utah							
Vermont							
Virginia							
West Virginia							

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Mandate or Voluntary?

Mandate	Voluntary
Compliance across required submitters	Compliance can be a challenge
Complete fields, even 'sensitive' fields	Sensitive fields may not be reported
45 CFR §164.512 (HIPAA) allows a covered entity to disclose PHI to public health entities or as otherwise required	Business associate agreements must be negotiated, Data Use Agreements
Data oversight boards and Public release of information required or permitted by state law	Who decides what is released and to whom may vary by initiative
Public utility/common database	Ownership, access, release challenges
TRANSPARENCY IN DATA, ANALYTICS, PROCESS	

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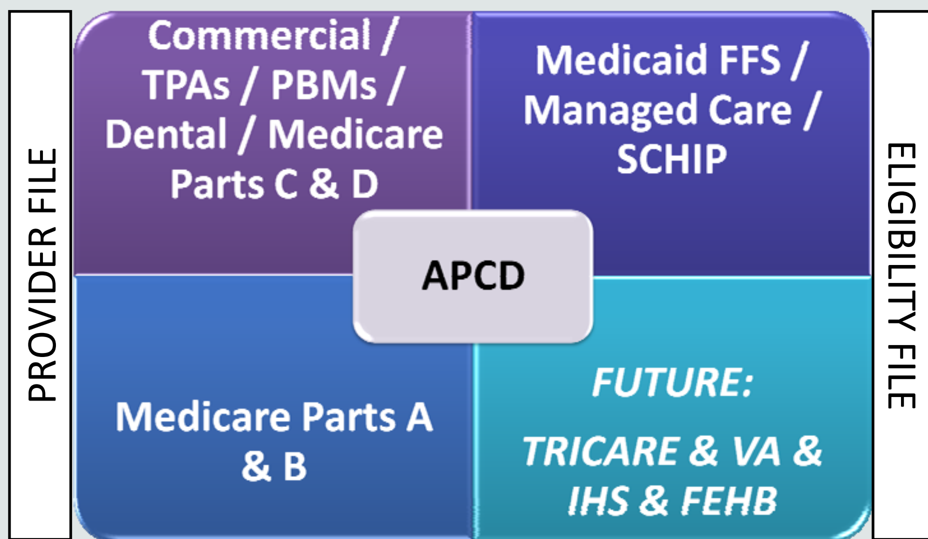
Typical APCD Data Sets



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Typically Included Information

- Member identification #
- Patient demographics(date of birth, gender, residence, relationship to subscriber)
- Type of product (HMO, POS, Indemnity, etc.)
- Type of contract (single person, family, etc.)
- Diagnosis codes (including E-codes)
- Procedure codes (ICD, CPT, HCPC, CDT)
- NDC code / generic indicator / other Rx
- Revenue codes
- Service dates
- Service provider (name, tax id, payer id, specialty code, city, state, zip code)
- Prescribing physician
- Plan charges & payments
- Member liabilities (co-pay, coinsurance, deductible)
- Date paid
- Type of bill
- Facility type
- Other 835/837 fields

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Typically Not Included Information

- Services provided to uninsured
- Denied claims
- Workers' compensation claims
- Referrals
- Test results from lab work, imaging, etc.
- Provider affiliations
- Premium information
- Capitation fees
- Administrative fees
- Back end settlement amounts
- Back end P4P or PCMH payments

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Health Costs: New Payment Reform Approaches Are Data-Intensive

- Both publicly funded programs and private insurance markets are talking a lot about Accountable Care Organizations and "all payer databases" as tools to contain health costs and improve quality.
  - (National Conference of State Legislatures)

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ACOs

Accountable care entities that assume financial risk from more than one payer to manage their overall financial health.

- Access to APCDs will allow accountable care entities to
  - Assess total cost of care for each patient that is attributed to them, independent of where the care was provided
  - Conduct comprehensive evaluations of all clinical programs (such as those associated with care coordination or population management)
  - Develop alternative payment arrangements (such as bundled payments and bonus payments on entire patient population) for clinicians who are part of the accountable care network and with partnering providers.
  - Apply predictive analytics to identify program opportunities and those patients where intervention will count most

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Something for Everyone

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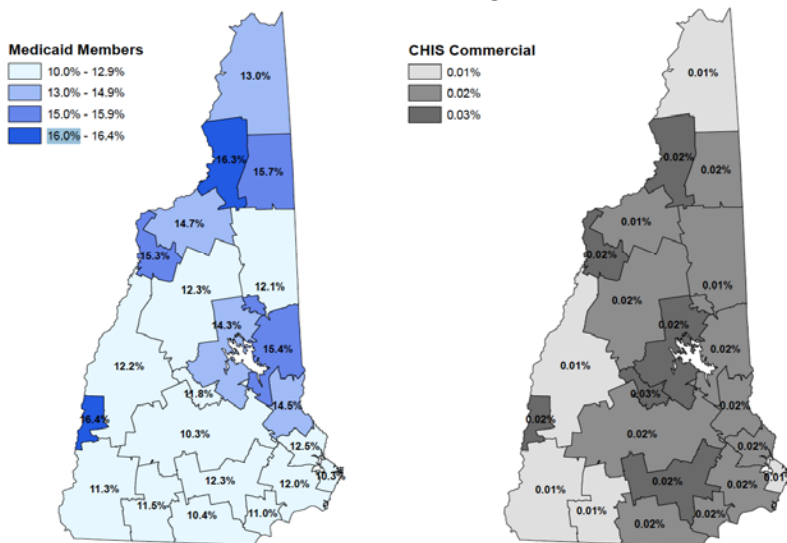
COPD Prevalence

Rates Standardized for Age



Source: NH DHHS

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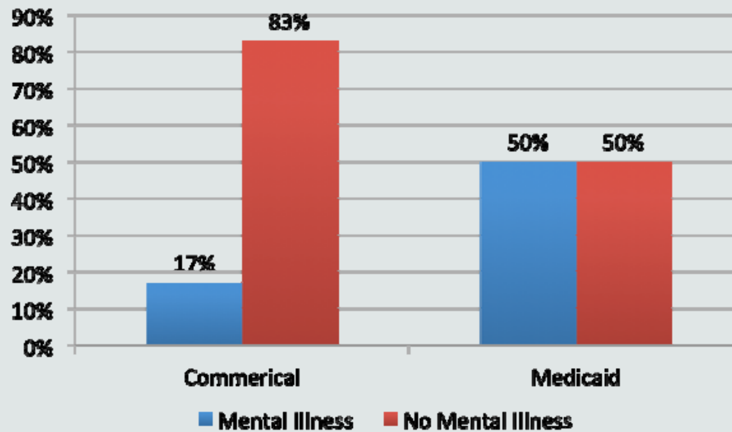
Commercial vs. Medicaid Adults > Age 19 with Mental Health Diagnosis, NH, 2007



SOURCE: NH Center for Public Policy Studies

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Medicaid Payment Rate Benchmarking

	Average Payment Including Patient Share, 2006			
Procedure Code	**Health Plan 1**	**Health Plan 2**	**Health Plan 3**	**NH Medicaid**
99203 Office/Outpatient Visit New Patient, 30min	$124	$115	$130	$42
99212 Office/Outpatient Visit Established Patient, 10min	$51	$48	$52	$30
99391 Preventive Medicine Visit Established Patient Age <1	$111	$102	$107	$61
90806 Individual psychotherapy in office/outpatient, 45-50min	$72	$71	$71	$61

SOURCE: NH DHHS

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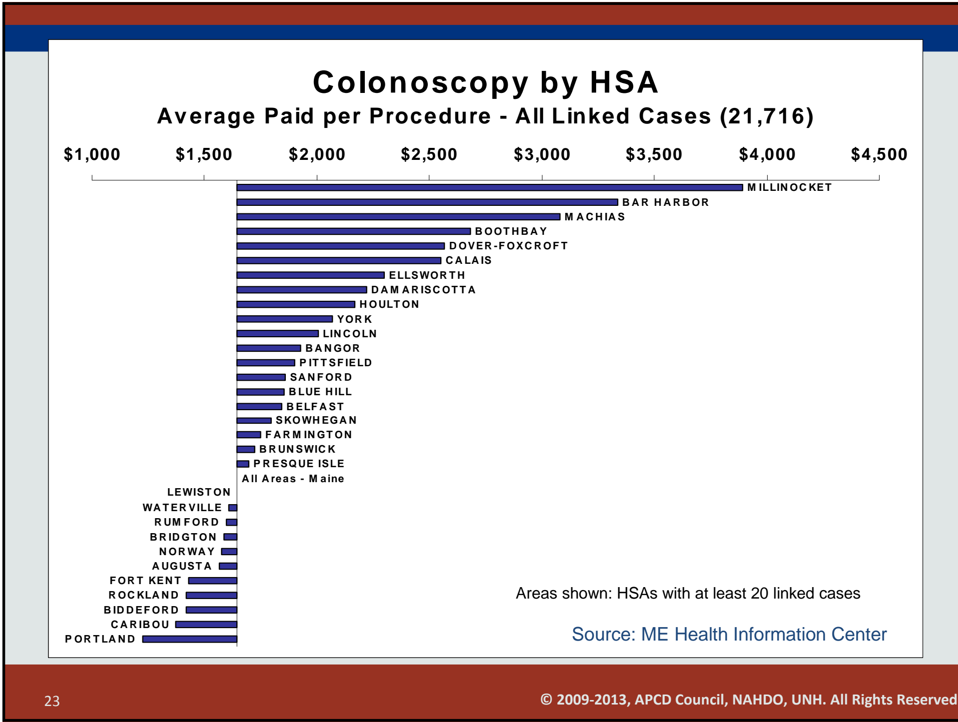

Preliminary Indicators Report, NH Medical Home Pilot
Total Costs by Practice Site vs. Non-Medical Home Sites

Practice Site	Total Cost PMPM Baseline Period January 2008 – June 2009	Total Cost PMPM Pilot Period July 2009 – September 2010
Site #1	$196	$118
Site #2	$218	$158
Site #3	$335	$229
Site #4	$172	$110
Site #5	$261	$207
Site #6	n/a	$225
Site #7	$251	$127
Site #8	$182	$128
Site #9	$203	$120
Total NH MH Sites	**$240**	**$151**
Total NH Non MH Sites	**$240**	**$222**

*Notes: PRELIMINARY DATA: Excludes pharmacy data, is not risk adjusted, is not annualized, and unadjusted for contractual differences.

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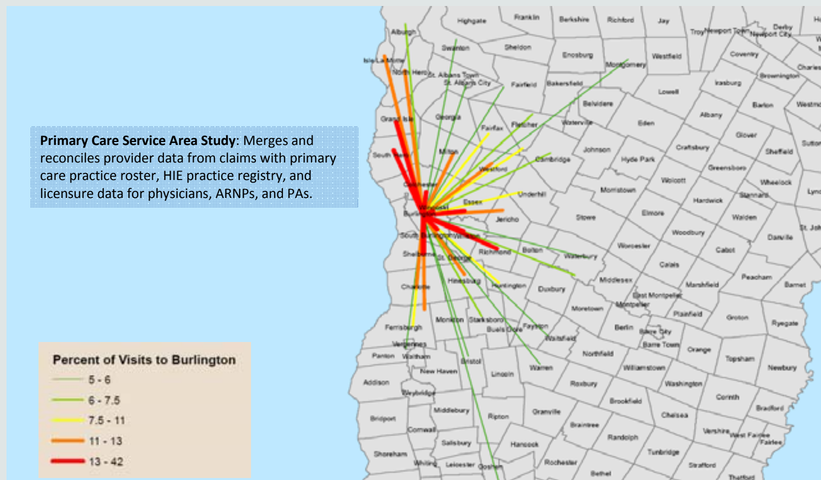
% of Each Vermont Town's Primary Care Visits to Burlington

49.6% of Burlington member visits (05401 Zip Code) were to providers in the 05401 Zip Code.

These data (05401 to 05401) cannot be shown using a spider diagram.



Source: VHCURES

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Firefox | Colorado All Payer Claims Database | +

https://www.cohealthdata.org/#/home

Colorado All Payer Claims Database

Home | Maps | Reports | Resources | About CIVHC

Welcome

Our current health care system is costly and doesn't always provide the best results. Many potential solutions exist, but one theme emerges consistently: improving the system starts with better information. This website securely compiles claims data from private and public health insurance payers to provide the most comprehensive picture of costs and service use in the state.

What's New

- **2012 comparison data now available!**
- **Medicaid vs. Commercial Payer** comparisons (click maps or reports)
- **30 Day All Cause Readmissions** (click maps or reports)
- **Percent Generic Scripts use** (click maps or reports)
- **Medicaid Readmissions (per population)** by county (graph)
- **Commercial Payer Readmissions (per population)** by county (graph)

How to Use the APCD

The APCD provides transparent data intended to support improving health, health care quality and containing costs. Communities, policy makers, and others can use information on this website to identify opportunities for improvement. View our Using the APCD to Achieve Triple Aim Webinar for more information.

Visit the maps and reports tabs to view a variety of interactive health care price and service comparisons.

Visit Resources for definitions and detailed instructions on the use of this site.

Find Costs and Utilization by Geography

Search for Colorado health care costs and utilization of services by co Code 3.

Choose one of the most viewed selections.

- Total Cost of Care (TCC)
- TCC Compared to Expected (C2E)
- Percent Generic Scripts
- 30 Day All Cause Readmissions (per population)
- ER Visits
- Diabetes Prevalence
- Asthma Prevalence
- Illness Burden

Total Cost of Care

represents the total dollars paid care services received by an ind as hospital, clinic, physician visit prescription costs. Amounts paid insurer and by the individual in th copays, deductibles and other c mechanisms are included. The displayed as a total dollars per p year. The rate represents the po in that geography, not where the were received.

View Map | Vie

View all Maps or Reports

Current Data in the APCD

The CO APCD currently includes 2009-2012 historic claims data from the largest commercial payers' individual and large-group fully-insured lines of business, plus Medicaid, representing over 2.5 million Coloradans.

Additional payer data, including Medicare and self-insured businesses will be added over time, eventually encompassing the vast majority of covered lives in Colorado. Click here to view a timeline.

Engage

Data in the APCD is updated periodically and additional reports and a generated regularly.

Join our email list and follow us on social media to receive notification updates and information.

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Firefox Researcher

www.mass.gov/chia/researcher/

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The Official Website of the Center for Health Information and Analysis

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CHIA Publications

This single page contains a list to all CHIA reports as well as links to older material published by the Division of Health Care Finance and Policy.

CHIA Data Resources

This section of the CHIA website contains links to the All-Payer Claims Database (APCD), Acute Hospital Case Mix Databases, Massachusetts Hospita Performance information, and various additional health care information and databases.

Information on the Massachusetts Health Care System

The Center for Health Information and Analysis (CHIA) monitors are a wide variety of health care indicators in Massachusetts. These indicators includ

- **Total Medical Expenses (TME):** TME represents the full amount paid to providers for health care services delivered to a payer's covered member (payer and member cost-sharing payments combined).
- **Relative Price (RP):** Relative price is a calculated measure that compares different provider prices within a payer's network for a standard mix of h services and insurance products.
- **Alternative Payment Methods (APM):** APM refers to methods of payment that are not solely based on fee-for-service reimbursements. Alternative methods include global payments, bundled payments, capitation payments, and other non-fee-for-service based payments.

For additional CHIA publications on utilization, quality, and access, please see our complete list of publications.

Needs and Future Priorities

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Capturing Supplemental Information

- Other fiscal information
  - Non-claims based payments, e.g.
    - Contract settlement payment
    - P4P payment
    - Quality bonus payment
    - Primary care centered medical home payment
  - Premium payments
- Benefit Structure Information
  - Plan Design details, e.g.
    - Deductible
    - Service limits

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Lessons Learned by States

- Develop Multi-Stakeholder Approach
  - Form Provider and Payer Relationships
  - Establish trust and process to disagree respectively
- Establish a common vision and goals
- Be Transparent and create structures that value progress
- Understand Uses and Limitations
- Seize Integration & Linkage Opportunities
- Develop Use Cases

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Price Transparency Facilitators

- At the minimum, publishing pricing information advances conversations about health care costs
- Rising out-of-pocket costs stimulate consumer interest
- State APCDs laying the groundwork: Maine and New Hampshire Health Cost Websites

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