



Introduction to All Payer Claims Databases

Prepared for

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I. INTRODUCTION

Total health care spending in Alaska reached \$7.5 billion in 2010, an increase of 40 percent since 2005¹ posing significant economic and public policy concerns. The Alaska Health Care Commission first established by executive order in 2009, and re-established by statute in 2010, is mandated to advise the State on policies for improving health and health care for all Alaskans. The Commission meets quarterly and has 14 members including representatives of the Department of Health and Social Services, hospital leadership, the primary care physician community, the health insurance industry, the military/VA health sector, the tribal health system, consumers, and legislators, among others. The Commission initially created a strategy for building a plan to transform Alaska's health care system.

This strategy includes the following steps:

- I. Develop a vision of the ideal health care system
- II. Study current health care challenges to inform policy recommendations
- III. Build the foundation of a strong health care system
- IV. Develop policies that enhance the consumer's role in health and health care
- V. Measure progress

The Commission has articulated a number of recommended solutions for improving the health care system in Alaska. The solutions include:

- Ensure the best available evidence is used for making decisions
- Enhance quality and efficiency of care on the front-end
- Increase price and quality transparency
- Pay for value
- Build the foundation of a strong health care system
- Focus on prevention

Many of these solutions require access to and the use of timely, accurate health care utilization, cost and quality information. For example, information is important to ensuring that the best available evidence is used by providers and patients in health care decision-making. Moreover, information is critical to increase price and quality transparency which will help educate consumers, providers, and policymakers about health care costs and quality.

The Alaska Health Care Commission has begun to explore options for gathering the necessary data to continue to implement the proposed solutions in order to achieve its goals. Freedman HealthCare is assisting the State with a study to assess the feasibility of establishing an All Payer Claims Database (APCD) or other comparable data system in Alaska. The goals of the study are: 1) to learn more about current data collection efforts in Alaska and where gaps exist; 2) to hear from stakeholders their ideas regarding how detailed utilization and

¹ Alaska Health Care Commission, 2011 Annual Report Highlights

cost data could be used to constrain costs and improve quality in Alaska and what are the barriers to collecting and using these data; and 3) to propose ideas for managing and sustaining a data collection system in the State. This briefing document provides an overview of APCDs. It discusses not only what they are and where they have been established, but how the data have been used, and the lessons learned from other states. Briefings will be scheduled over the next several weeks to hear from stakeholders their thoughts regarding how an APCD or other comparable data system can help fulfill Alaska's vision of ensuring a health care system that produces improved health status, provides value for Alaskan's health care dollar, and delivers consumer and provider satisfaction.

II. BACKGROUND

What is an All Payer Claims Database (APCD)?

Most states collect hospital discharge data that typically include statewide all-payer data for inpatient hospital stays. These data provide important population-based information including patient demographics, diagnoses and procedures for inpatient stays. However, as more care has moved to outpatient settings, these data are quite limited in assessing the costs and quality of a state's health care system.

All Payer Claim Databases (APCDs) were designed to address a need for comprehensive information about health and healthcare across all settings of care. The motivations for collecting this data include informing efforts around cost containment and quality improvement, assessing access or barriers to care, studying utilization patterns, and informing policy decisions.

Every health encounter creates a claim for payment. Both public and private insurance plans routinely aggregate these claims data into their own administrative databases. APCDs combine data from all payers in a state, providing statewide information on costs, quality, and utilization patterns. The payers include Medicare, Medicaid, private insurers, dental insurers, children's health insurance and state employee benefit programs, and self-insured employer plans. The databases generally include data on eligibility; medical, pharmacy, and dental claims; and provider information. As with all data sets, there are limitations with APCD data, but capturing information from most - if not all - of the insured encounters in a state can create a powerful information source.

APCDs may be governed in a variety of ways, ranging from entirely public entities (housed in a state agency), a private entity (such as a non-State non-profit organization), or a hybrid model combining the two. Data submission can occur either as a statutory/regulatory mandate (requiring all payers to contribute data by law), or voluntary efforts.

III. POTENTIAL BENEFITS

How can APCDs be useful?

Large claims data sets, such as APCDs, can be used by a number of different stakeholders within a state for various purposes. Comprehensive information on disease incidence, treatment costs, and health outcomes is essential for informing and evaluating state health policies. These data can be used to give consumers the tools to begin to take a more active role in their health and health care and to make more informed decisions. Providers and payers can use these data to improve quality and develop appropriate payment policies. As discussed earlier, a growing number of states are developing APCDs. Below is a brief discussion on several ways APCDs can and have been used in states by various stakeholders.

Public Reporting on Price and Quality of Health Care Services

An APCD can be used by public or private entities to increase transparency in cost and quality data. Two states that have used the APCD in this way are Massachusetts and New Hampshire. The Massachusetts “[My Health Care Options](#)” website displays cost and related quality measures for a limited set of hospital-based procedures. Consumers are able to search by provider name, condition or procedure, or a radius around a particular zip code. This website provides explanation and detail at three levels: summary ratings with one to three dollar signs and stars; a second screen with detail about the quality rating, and a third level showing the cost measures and comparisons to statewide benchmarks. The [New Hampshire Health Cost](#) website uses APCD information to generate an estimated cost of a procedure by facility. Using additional information provided by insurers, the tool uses the consumer’s deductibles and co-pays to show the consumer’s estimated total cost, as well the precision of the estimate.

Clinical Performance Improvement

Large claims databases offer important opportunities to identify high performing clinical groups and learn how high quality, effective clinicians and systems deliver care. APCDs seek to build a longitudinal portrait of each individual’s claims. This data provides a strong foundation for standardized metrics that help clinicians identify promising practices for improving care. In Minnesota and Colorado, APCD data will be used to provide cross-payer quality reports that allow providers to look at performance across the entire practice, eliminating the need to read and interpret reports from all their payers. Voluntary data collection organizations - the Wisconsin Health Information Organization and the Puget Sound Health Alliance in Washington state - offer provider specific, cross-payer quality data. In Rhode Island, the Rhode Island Quality Institute is collecting claims data to evaluate the effect of the federally funded Beacon Community Program on provider practices, with particular emphasis on the effect of electronic medical records and other practice-level technology investments.

Looking ahead, the “next generation” of APCDs (Colorado, Connecticut and New York) is building capacity to align claims-based quality information with outcome results drawn from health information exchanges (HIE). To accomplish this vision, designers are building processes that uniquely identify each individual in the APCD

so that other data sets can use the same processes to facilitate matching. Analysis drawn from both data sources supports clinical effectiveness research to identify best practices.

Information on Health Care Quality and Cost Trends for Public Policy Decision Makers

A number of states have used data from an APCD to provide additional analyses on quality and cost trends to inform public policy decision makers. Maine has used its database extensively to document the cost of certain adverse health events and evaluate the effectiveness of a medical homes pilot, while New Hampshire constructed a comprehensive health care information system that allows a user to analyze any number of health system questions. Vermont has used its APCD for an expenditure analysis by type of service and several studies on provider reimbursement for primary care services have also been conducted. Massachusetts also has conducted extensive analyses on its health care system using a large multi-insurer claims database. Studies have included variation in cost by provider, quality trends, and trends in utilization of various health care services.

Studying Geographic Variation

APCDs can be used by program administrators of public programs to better understand patterns of utilization and the value of care delivered to a given population in a geographic region. One of the best examples of work in this area is the [Dartmouth Atlas of Health Care](#). Using one of the largest health care claims databases (Medicare), the Dartmouth Atlas has documented significant differences in how elderly Americans use health care resources, and the influence of the local supply of health care resources on the rates of use. An important discovery about geographic variation is that differences in spending across regions do not correlate with health outcomes. While patients in high spending regions receive more health care, several studies have found that those regions do not achieve better outcomes. In fact, in several studies, higher spending regions were associated with poorer outcomes. An APCD that includes Medicare, Medicaid and private payer data extends the Dartmouth lens and helps examine the total cost of care for similar patients regardless of payer and reimbursement methodology. Such data eliminates “quality silos” of past studies and supports a more robust conversation about care delivery strategies.

Population Health Analysis for Public Health Officials

APCDs could dramatically alter the analyses conducted by public health programs to develop, evaluate and report on the impact they have on their targeted, and oftentimes underserved, communities. This impact could also include direct cost savings and cost benefit analysis as a result of specific program interventions. In general, the data included in an APCD can address crucial surveillance and monitoring gaps that exist across programs within a state and can be used to:

- estimate prevalence of disease/condition;
- assess standards of care for disease/condition;
- examine the financial impact of disease/condition; and
- evaluate program impact.

Specific examples of how APCD can be used include:

- Supplement existing surveillance reports with expanded measures of morbidity using claims, pharmacy, and product file data. Current surveillance reports focus on outcomes such as mortality, self-reported illness, hospitalization, and cancer incidence. Using APCD data could assist in more fully understanding the spectrum of population-based illness in Alaska.
- Use pharmacy claims data for targeted monitoring of the quality of primary care and nursing home medication management in the elderly, identify inappropriate prescription patterns, preventable adverse effects and the association of such effects with preexisting conditions.
- Assess patterns in overuse of various medical services including imaging.
- Develop measures around the burden of obesity and other risk factors on health care costs.

IV. KEY MILESTONES IN DEVELOPING AN APCD

The implementation process for an APCD (or any similar, new health database) requires some milestones to be met before any data can be seen. Some of the identified milestones can be worked on and accomplished concurrently, and the specific timeline for many will vary from state to state.

APCD Advisory Board (or similar group): This group of varied stakeholders should be created and convened to identify internal (within State) and external stakeholders; create sub-committees to address specific issues, such as technical requirements and data use policies; and make recommendations or decisions on next steps.

Data Collection Authority: A state needs to determine its legal ability to ask payers to submit data toward the APCD, either through legislation or executive order. This will determine key aspects of organization and data collection permission, such as the entity in charge of administering the APCD and the state's stance on the collection of personal identifiers.

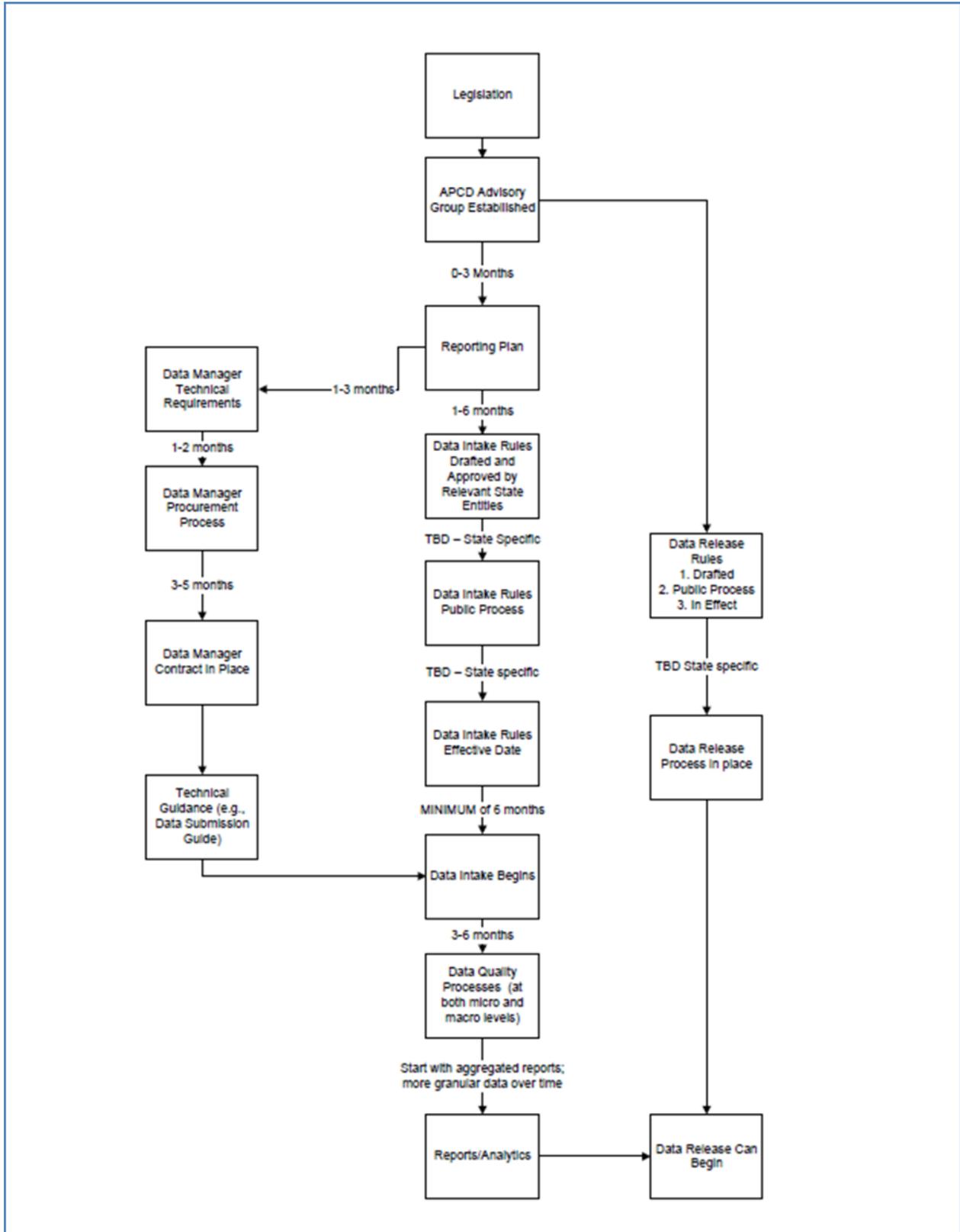
Data Collection Rules: Once authority has been established, a state needs to define some technical parameters for its APCD. The creation and release of regulations and/or a Technical Submission Manual for payers will identify all data submitters in the APCD and the format by which it is received. For example, some important decision points in this process may be: whether or not to include Pharmacy Benefit Managers (PBMs) as mandatory submitters; a plan to receive Medicare data; identifying the number and types of claims files a payer should submit (Medical, Pharmaceutical); a schedule for regular data submission.

Data Release Rules: A vision and plan for data release should ideally be the conversation driver in implementing an APCD. When there is an intended purpose for the data, the state will be more easily able to identify specific audiences and consumers, and therefore determine level of access to the data at varying levels, if desired. Much of this would be encompassed in a state's APCD regulations.

Technical Build: When a state has authority, collection rules, and release standards in place, the data submission can begin. In the beginning stages of data submission there will be a need for rigorous data quality checks and feedback with payers to ensure accuracy. A state may choose to engage an outside vendor to

assist in carrying out APCD implementation at various levels: advisement; data collection, cleaning, and warehousing; data analytics and report production; data access and delivery mechanisms.

The following graphic depicts a typical APCD implementation road map:



V. LESSONS LEARNED

Each state's APCD is different, emerging from their particular vision about health care quality, measurement and value. Yet, over the past five years, several universal themes have emerged from APCD states as they have undertaken the development and implementation process.

Convene a broadly representative stakeholder group to provide advisement during the development and implementation phases. The Tennessee Health Information Committee, Colorado APCD Advisory Group, and Oregon Health Authority demonstrate the value of diverse stakeholders providing guidance and oversight to the team responsible for day-to-day operations; serving as “ambassadors” to peers and colleagues; championing the value an APCD to skeptics; and offering important insight to data reporters, data users, and those being measured.

Legislative authorization and clear regulatory guidance improve the quality and breadth of APCDs. A standardized set of data submission rules allows the APCD authority to streamline construction of the database. Legislation identifies the types of insurance carriers and providers that are required to submit and provides the APCD administrator with clear public health authority to collect data. In the early years of APCDs, regulatory language often included detailed field specifications and instructions to the data submitters. More recently, however, legislation has shifted to empower an advisory group to help shape the regulations around data intake and release.

Establish clear criteria for permitted uses (“releases”) of the APCD data. Including diverse stakeholders in the decision making process will help determine whether a request for the data is consistent with the state's expressed policy. Colorado, Massachusetts and Oregon have established broad-based data release bodies. New Hampshire, Maine and Massachusetts post applications for APCD data and allow for public comment prior to review.

Work closely with health plans from the start. It is critical that APCDs work closely with health plans as the key data submitters to develop data intake specifications and regulatory requirements, especially given the challenges and limitations of claims payment systems. Health plans have urged states to allow between six and nine months' lead time before data submission begins.

Create a tiered or phased approach to reporting. Similar to other complex datasets with multiple years of data such as Hospital Discharge Datasets, APCDs have become more robust over time. As data submitters improve compliance, the APCD can offer more highly aggregated population reports to demonstrate proof of concept and to identify areas in need of further quality efforts. Creating a tiered approach allows the state to use preliminary reports to set the stage for more detailed examinations of health care service and utilization in the future. Tennessee and Colorado are two states that have successfully used this approach.

Embrace transparency. Successful APCDs have a “no surprises” policy for issuing public reports that include comparisons across settings or providers. In Massachusetts, for example, the methodology for evaluating variation in cost for selected services was shared first with hospitals to allow time for public comment before

results were published on a consumer-facing website.

Create a sustainability plan to cover data intake and reporting functions. APCDs typically require a large start-up investment of time and resources before any reports can be delivered. To realize the return on investment, effective APCD planning includes a strategy for creating ongoing revenue to support operating costs. Most APCDs have been supported by state appropriations; Tennessee and New Hampshire, for example, received operations support from Medicaid funding. APCDs currently in development in Rhode Island, Connecticut and New York were awarded startup funding from Exchange establishment grants and will develop on-going funding strategies as part of the implementation process. The Colorado APCD received no state appropriations and successfully obtained startup funding through grants and foundation funding; later, data use fees and contracts with state agencies will provide ongoing support.

Build a unique member ID to set the stage for aligning with other data sources. One of the goals of an APCD is to create a person level, longitudinal portrait of care for use in diverse reporting options. Advanced technological matching processes allow APCDs to assign a unique identifier that is consistent within and across payers' records. The unique member identifier can also be created from clinical records and lab results. Using this member identifier, the APCD can support clinical effectiveness reviews, cross payer quality reports and outcomes research.

Robust privacy and security measures are essential. An APCD must achieve and maintain the highest levels of security around protected health information. Current security standards call for encryption at motion and at rest. Whether the data manager is a contracted vendor or an in-house operation in a state agency, the APCD must demonstrate the same or greater protections than the health plans maintain.

VI. NEXT STEPS

In conjunction with the Alaska Health Care Commission, Freedman HealthCare will host and conduct stakeholder information sessions to supplement this briefing paper. The State welcomes any feedback and invites you to participate in the question and answer session following the presentation either in person, via webinar, or separately contacting the Freedman HealthCare team via email, (pтрivedi@freedmanhealthcare.com). Gathered stakeholder responses will be presented at the Health Care Commission meeting on October 11, 2012.