# All Payer Claims Databases: Options for Consideration Feasibility Study Final Report

**Presentation to the**

**Alaska Health Care Commission**

**March 7, 2013**

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# Overview of the Presentation

- Project summary

- Health System Data and APCDs

- Options for informed decision making

- Compare and contrast

- Transparency options

- Questions

# HCC Core Strategies for Cost Containment and Quality Improvement

- Ensure the best available evidence is used for decision making
- Increase price and quality transparency
- Pay for value
- Engage employers to improve health plans and employee wellness
- Enhance quality and efficiency of care on the front-end
- Increase dignity and quality of care for seriously and terminally ill patients
- Focus on prevention
- Build the foundation of a sustainable health care system

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# Project Goals

- Understand health care delivery, data, and reporting environment in AK and where gaps exist

- Understand how an APCD or other data solutions will integrate with AK's current data initiatives

- Explore options other than APCD for meeting data reporting goals

- Assess stakeholder readiness

- Provide recommendations

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# Project Overview

- Stakeholder interviews and focus groups

- Review existing health care data collection options

- Obtain feedback from the HCC at the October 2012 meeting

- Develop options based on feedback

- Review options with the HCC in March 2013

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# How APCDs Support Health System Transformation

- Data from all settings of care: inpatient, outpatient, Rx
- Longitudinal look at service utilization
- Empower consumers to choose:
  - High quality care
  - High value care
- Provide data for benchmarks and other progress measures for policy and programmatic interventions
- Improve understanding of population health status
- Build analytic capacity available to all health policy decision makers
- Provide data for clinical quality improvement

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# Examples of APCD Reporting and Analysis

- New Hampshire
  - Consumer facing cost of procedure website
  - Cost driver study currently in progress
- Maine
  - State employee  health insurance benefit design
- Vermont
  - Health care report card
- Minnesota
  - Provider peer comparisons
- Massachusetts
  - Cost trends
  - Federal Premium Stabilization --Risk Adjustment Program

# What We Learned: Interviews and Focus Groups

- Ongoing efforts to align Alaska's health data systems

- High desire for data driven decision making

- Alaska's unique challenges (not like the lower 48)

- Alaska is in the beginning stages of broad-based health care collection and analysis

- Any data is an important first step for driving change

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# What We learned:  Alaska's Health System Data and Information Resources

- National datasets (federal)
  - Census data
  - Other surveys (BRFSS, MEPS)
- Partial Views
  - Health plan data (MarketScan, Health Care Cost Institute)
  - Hospital Performance (Leapfrog)
- State datasets
  - Hospital discharge data
  - IBIS
    - Survey data
    - Other information
- Future plans for:
  - Medicaid data and reporting

# Stakeholders' Health Care Data Wish List

- Health status of all Alaskans
- Understanding health care cost and utilization trends
- Understanding how cost shifting occurs
- Standardized benchmarks across payers and populations
- Support for consumer choice based on quality and cost
- Forgone health care due to access or cost
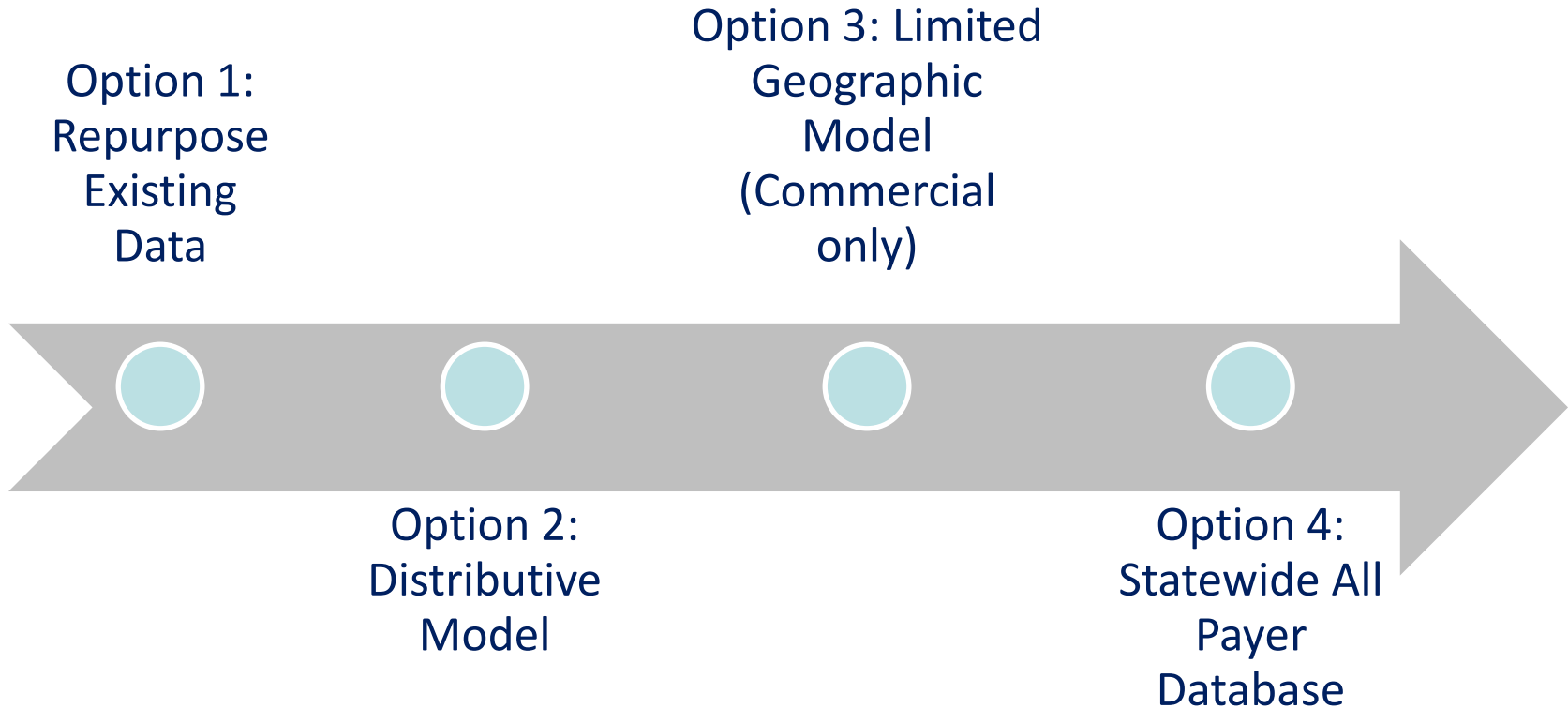- Consumer satisfaction
- Clinical outcomes

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# What We Learned:
## Feedback from HCC October 2012 Meeting

- Cost drivers need to be monitored on an ongoing basis.
- Stakeholders are ready to consider new data collection and analytic strategies.
- Integrated care systems (Indian Health, Air Force) are actively using health data collection and analysis to improve care and manage cost.
- High interest in linking findings from data and analytics directly to cost savings.
- Emerging interest in how cost transparency could have a positive impact on the Alaska health care market.

# Who Could Use More Data?

- Consumers
  - Best value in light of higher co-pays and deductibles
  - Increase  engagement in care

- Providers
  - Best practices –  Models for wider adoption
  - Understanding differences in health care utilization across settings
  - Assessing readmissions
  - Clinical quality improvement support

- Employers
  - Self-insured– best care at lowest cost
  - Small business – selecting affordable products

- Policy and Decision Makers
  - View into health system activity
  - Examine effect of public policy changes
  - Shared access to reliable source of information
  - Views of cross-payer, cross provider activity over time

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# Options for Collecting Data and Creating Reports and Analysis



Option 1: Repurpose Existing Data

Option 2: Distributive Model

Option 3: Limited Geographic Model (Commercial only)

Option 4: Statewide All Payer Database

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# Option 1: Repurpose Existing Data

- Use existing federal, state and national data resources
  - CMS Hospital Compare
  - US Census American Community Survey
  - Kaiser State Health Facts
  - Alaska Indicator-Based Information System/Behavioral Risk Factor Surveillance System
  - Hospital Discharge Data
- Compile in standardized format
- Examples:
  - Massachusetts Key Indicators
  - Commonwealth Fund Local ScoreCard
  - California Health Foundation "Health Care Costs 101"
- Time from start to first report:  three to four months

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# Option 1: Strengths/Limitations

- Strengths
  - No surprises: re-uses reports and information released by other entities
  - Data is easily obtained and is at an aggregate level (no privacy issues)
  - "Data management" is minimal; spreadsheets are sufficient
- Limitations
  - Fragmented view of health system activity
  - Incomplete information about everyone in Alaska
  - No drill down or providing customized reports
  - Methodologies may change, limiting trend analysis

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# Option 2:   Distributive Model

- Annual, voluntary data submissions from commercial payers combined with Medicare and Medicaid data, as available

- Opportunity to collaborate with Indian Health Service, TRICARE and Veteran's Administration on data sharing

- Large volume of data will need warehousing and business intelligence tools

- No personal information collected

- Similar models:
  - MarketScan
  - Health Care Cost Institute

- Time from start to first report:  Approximately 12 months

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# Option 2: Strengths and Limitations

- Strengths
  - Statutory authority not necessarily required
  - Collaborative process (not regulatory) with commercial payers
  - Small number of key commercial plans
  - Potential for data from federal entities
  - Supports payment reform analysis
  - Builds a record of successful data use
  - De-identified data mitigates privacy concerns
  - Annual data submission is a smaller "ask" than quarterly or monthly files
- Limitations
  - Voluntary data submission may vary in timing, format and quality
  - Self-insured data is less likely to be shared with the state
  - Longitudinal analysis only for those who maintain same coverage, same plan
  - Uses of the data will be limited by terms and conditions of data use agreements between health plans and the state

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# Option 3: Limited Geographic Model

- Recognizing the differences in the state's distribution of people and providers, this model focuses on areas where consumers have a choice in providers.

- Focus on commercial and third party administrator data

- Analysis of care patterns, utilization trends and costs, provider outcomes (as seen in administrative data)

- Uses statutory authority to require commercial carriers to submit periodic files in a standard format; sets and monitors data quality standards

- Build on work underway for the new MMIS Data Warehouse

- Examples:
  – Regional Collaboratives
  – Washington State Puget Sound Alliance
  – City specific?

- Time from start to first report: 18-22 months

# Option 3: Strengths and Limitations

- Strengths:
  - Supports analysis of health care reform efforts that affect most of the state's population (80%)
    - Allows robust analysis of utilization and cost for areas with a local choice of providers
  - Avoids "small cell size" issues in less populated areas
  - More compact area
  - Statistical models can extend analysis to other areas

- Limitations
  - Similar level of effort as a full APCD
  - Limited insight on quality and utilization for the state as a whole
  - Limits comparisons between an urban area and a resident's local health care options in less populated parts of the state
  - Medicaid Data Warehouse goals and timeline may not align with this project

# Option 4:  APCD

- Creates a robust data source for advanced analytics about health care across the state
  - Supports the broadest range of analysis for policy development, research, and health system transformation
- Legislative authority allows creating and monitoring data quality
- Data sources:
  - Commercial payers submit periodic files in a standard format
  - State agencies contribute  Medicaid, vital statistics
  - Medicare data available; work with other federal agencies for full portrait of health care spending and utilization
- Build on others states' APCD knowledge and experience
- Examples:  Colorado, Oregon, Utah, New Hampshire plus 7 more
- Time from start (legislative approval) to first report: 16-24 months

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# Option 4: Strengths and Limitations

- Strengths:
  - Single most complete source of information
  - Three largest commercial carriers in Alaska are familiar with APCD submission processes in other states
  - Accommodates Medicaid and Medicare data sources
  - Opportunity to lead the nation and work with federal agencies that have not yet submitted data to APCDs, e.g. Veterans Administration
  - Credible source of state-specific, high quality information

- Limitations
  - APCDs development schedule may lag behind payment reform timeline
  - Complex development and management effort requires a multi-year commitment of energy and resources
  - High level of effort to engage health care community in data-driven decision making
  - Uncertainty about how the Medicaid Data Warehouse timeline might affect a joint effort
  - Data from Federal agencies other than Medicare will require negotiation
  - Short legislative session adds to timeline

# Similarities and Differences among the Options

- Similarities
  - Gaps
    - No uninsured data
    - Forgone health care due to access or cost
    - Consumer satisfaction
    - Clinical outcomes
- Differences
  - Level of detail
  - Comprehensiveness
  - Use by multiple stakeholder communities
  - Investment and Operations
  - Cost

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# Support for Analytic Needs

| Option 1 Repurpose Existing Data | Option 2 Distributive Model | Option 3 Limited Geographic Model | Option 4 All Payer Claims Database |
|---|---|---|---|
| • Very low<br>• Statewide or summary level data lacks detail; Hospital Discharge data is incomplete; other data is too highly aggregated to support modeling and analytics | • Low to Moderate<br>• Voluntary data submission limits the level of detail for inputs into models and analysis | • High<br>• Focus on highly populated areas; ongoing data collection for trend monitoring and analysis | • High<br>• Fully supports advanced modeling and analytic techniques, including sensitivity analysis, population health, and trends monitoring and analysis |

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# Evaluation of the 4 Options
# Level of Effort to Overcome Barriers

| Option 1 Repurpose Existing Data | Option 2 Distributive Model | Option 3 Limited Geographic Model | Option 4 All Payer Claims Database |
|---|---|---|---|
| • Moderate level<br><br>• Obtaining federal data requires negotiations<br>• Limited availability of complete state-specific data<br>• Challenging to reconcile metrics based on different data sources | • Moderate/High level<br><br>• Negotiating data agreements with commercial carriers<br>• Federal data negotiations | • High Level<br><br>• Legislative action<br>• Assuring privacy controls<br>• Obtaining start up resources and maintaining the investment<br>• Creating a shared understanding of the uses of the data<br>• Federal data negotiations | • High Level<br><br>• Legislative action<br>• Assuring privacy controls<br>• Obtaining start up resources and maintaining the investment<br>• Creating a shared understanding of the uses of the data<br>• Federal data negotiations |

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## Evaluation of the 4 Options
# Estimated Cost: Data Collection to First Report

|  | Option 1 Repurpose Existing Data | Option 2 Distributive Model | Option 3 Limited Geographic Model | Option 4 All Payer Claims Database |
|---|---|---|---|---|
| **Start Up** | $150,000 | $375,000-$575,000 | $400,000 | $650,000 |
| **Year 1 Operations** | $60,000 - $175,000 | $175,000-$600,000 | $195,000-$500,000 | $345,000-$900,000 |
| **Total** | $210,000 – $325,000 | $550,000-$1,125,000 | $595,000-$900,000 | $995,000-$1,550,000 |
| **Addresses HCC's Goals?** | Least useful | Somewhat useful | Moderately useful | Highly useful |
| **Relative strength** | Low | Moderate | Moderate | High |

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# Summary

- Data gaps limit the choices and options for policy makers, providers, payers and consumers

- Reports and analysis produced from an APCD meet more of the expressed needs than any other option

- APCD data would support detailed and unbiased information for cost transparency initiatives

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# Using Data in for Health Care Cost and Transparency

- Different models of data delivery to meet varied needs and purposes
    - Research data sets
    - Policy reports
- Growing focus on how individuals are engaged in health care decision making
- Wider awareness of how much an individual pays for each health care visit

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# Federal Health Care Reporting Initiatives and Tools

- Hospital Compare

- American Community Survey

- NCQA standard measures

- AHRQ tools for quality measures

# Transparency Initiatives in Other States

- Offering consumers information to support choice of medical providers and settings
- Driven by:
  - State agencies and legislatures
  - Nonprofit efforts
  - Commercial market
- Can acquire the data through APCDs, special data calls, hospital discharge data sets and other sources.
- Statutorily mandated

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# Transparency at the Site of Care

- Hospital-based transparency
  - Provide written estimate of costs to the patient:  California, Colorado, Nebraska
  - Maintain a uniform list of billed charges: Nevada
  - Provide cost estimate upon patient request:  South Dakota, Texas
- Clinic or Medical Office
  - Publish and post a schedule:  Florida

# Reporting Hospital Charges To The State

- Usually based on hospital discharge data sets
- Published in a report or on a website: Arizona, Arkansas, Delaware, Florida, Indiana, Iowa, Kentucky, Maryland, New Hampshire, New Jersey, Oregon, South Dakota, Wisconsin, Wyoming
- Charge data differs from cost to consumer
- Voluntary disclosure:  Louisiana, Michigan (Medicare only)

# Wyoming Hospital Association

# Consumer-friendly Information Based On Actual Amounts Paid

- Use claims data to calculate average costs

- All services:  New Hampshire, Maine

- 30 hospital inpatient and outpatient admissions (DRGS)/procedures: Massachusetts

- "Top 25" based on carrier reimbursement (pre-APCD): Colorado

-  103 common procedures: Minnesota

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# New Hampshire Cost Estimator

NH HEALTH COST

## Detailed estimates for Arthroscopic Knee Surgery (outpatient)

Procedure: Arthroscopic Knee Surgery (outpatient)
Insurance Plan: Anthem - NH, Health Maintenance Organization (HMO)
Within: 20 miles of 03755
Deductible and Coinsurance Amount: $800.00 / 0%

| Lead Provider Name | Estimate of What you Will Pay | Estimate of What Insurance Will Pay | Estimate of Combined Payments | Precision of the Cost Estimate | Typical Patient Complexity | Contact Info |
|---|---|---|---|---|---|---|
| DARTMOUTH HITCHCOCK SOUTH | $800 | $3482 | $4282 | HIGH | MEDIUM | DARTMOUTH HITCHCOCK SOUTH 800.238.0505 |
| MARY HITCHCOCK MEMORIAL HOSPITAL | $800 | $4929 | $5729 | HIGH | LOW | MARY HITCHCOCK MEMORIAL HOSPITAL 603.650.5000 |
| ALICE PECK DAY MEMORIAL HOSPITAL | $800 | $6733 | $7533 | HIGH | HIGH | ALICE PECK DAY MEMORIAL HOSPITAL 603.448.3121 |

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# Nonprofit and Commercial Transparency Initiatives

- Nonprofit:
  - Health Care Incentives Improvement, Inc. Transparency Report Card (procedure cost)
  - Leapfrog (hospital quality)
  - Consumer Reports (quality)
- Commercial:
  - Angie's List
  - Castlight, Change HealthCare.com, HealthCare Blue Book
  - US News and World Reports hospital and health plan rankings
  - JC Powers surveys
  - Health plans' members-only websites
    - Aetna
    - United

# Questions?

# Thank you!

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