All-Payer Claims Databases: Current Status and Future Directions

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About the APCD Council

The APCD Council is a learning collaborative of government, private, non-profit, and academic organizations focused on improving the development and deployment of state-based all payer claims databases (APCDs). The APCD Council is convened and coordinated by the Institute for Health Policy and Practice (IHPP) at the University of New Hampshire (UNH) and the National Association of Health Data Organizations (NAHDO).

Our Work

• Early Stage Technical Assistance to States
• Shared Learning
• Catalyzing States to Achieve Mutual Goals
• Advocacy for State and Federal policies
What is an All-Payer Claims Database (APCD)?

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)
APCD Global “Business Case” for States

- APCDs provide an understanding for a broad set of the state’s insured population.
- APCDs are filling critical information gaps for state agencies.
- APCDs build off of experience with and supplement other healthcare data systems.
March 2011 State Progress Map
Typically Included Information

- Social Security Number (often encrypted)
- 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
Typically Not Included Information

- Services provided to uninsured
- Denied claims
- Workers’ compensation claims
- Referrals
- Test results from lab work, imaging, etc.
- Premium information*
- Alternative payment models*

* States exploring/piloting collection
Typical APCD Data Sets

Provider File
- Commercial / TPAs / PBM's / Dental / Medicare Parts C & D
- Medicare Parts A & B

Eligibility File
- Medicaid FFS / Managed Care / SCHIP
- FUTURE: TRICARE & VA & IHS & FEHB
Framework for APCD Development
Lessons Learned by States

- Develop Multi-Stakeholder Approach
  - Form Provider Relationships
  - Form Payer Relationships
- Be Transparent and Document
- Understand Uses and Limitations
- Seize Integration and Linkage Opportunities
- Develop Use Cases
• **Providers:**
  – Quality and utilization of provider and peer group care
  – Identify and monitor quality improvement projects.

• **Payers:**
  – Comparative performance of provider networks to statewide benchmarks
  – Identify variation in utilization and cost efficiency.

• **Employers:**
  – Increased transparency in the cost and utilization of health care to stabilize the cost of health coverage for employers.
  – Larger population/sample size and benchmarks.

• **Policy Makers:**
  – Inform support public policy with information on how the health care system is operating and support data-driven improvements in access, quality and cost of healthcare.

• **Public Health Practitioners:**
  – Variation in utilization of health care services to target “hot spot” opportunities to improve population health
  – Cost burden of chronic diseases such as diabetes, cardiovascular disease and asthma.
  – Evaluate public health programs
State Use Case Examples

- Understanding overall and categorical costs for care (e.g., CO, NH, ME, VT, UT, MA, MD)
- Consumer tools (e.g., MA, NH, ME)
- Intrastate cost variation (e.g., CO, ME, NH, VT)
- Benchmarks for purchasers (e.g., NH)
- Medical home evaluation (e.g., VT, NH)
- Accountable care – regional cost profiles (e.g., NH)
- Risk assessment (e.g., MA)
- Population health and management (e.g., OR, MA, NH)
- Low value services and waste calculators (e.g., VA, MN)
- Opioid patterns of prescribing/use (e.g., AR, UT)
Welcome to the APCD Showcase where examples from state all-payer claims databases (APCDs) have been organized in order to provide stakeholders with tangible examples of APCD reports and websites. The examples have been organized by intended audience, and are also searchable by additional criteria. We invite you to explore the site and learn more about the value that APCDs provide to states and their stakeholders.

Choose from the categories below or See all Case Studies >
Estimate of Primary Care Spending: OR

Per-member per-month (PMPM) primary care spending
In 2016, the average PMPM primary care spending for commercial plans was $44. The carriers’ spending ranged from $13 PMPM to $67 PMPM. Among most carriers, the proportion of total primary care that is non-claims-based is less than 1 percent.

<table>
<thead>
<tr>
<th>PMPM primary care</th>
<th>PMPM non-primary care</th>
<th>Primary care as %</th>
<th>Of primary care, non-claims-based</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kaser Foundation Health Plan of the Northwest</td>
<td>$67</td>
<td>$326</td>
<td>17.1%</td>
</tr>
<tr>
<td>Providence Health Plan</td>
<td>$36</td>
<td>$248</td>
<td>12.9%</td>
</tr>
<tr>
<td>Moda Health Plan, Inc.</td>
<td>$36</td>
<td>$303</td>
<td>10.6%</td>
</tr>
<tr>
<td>PacificSource Health Plans</td>
<td>$33</td>
<td>$249</td>
<td>11.8%</td>
</tr>
<tr>
<td>UnitedHealthcare Insurance Company</td>
<td>$29</td>
<td>$204</td>
<td>12.6%</td>
</tr>
<tr>
<td>Regence BlueCross BlueShield of Oregon</td>
<td>$29</td>
<td>$241</td>
<td>10.6%</td>
</tr>
<tr>
<td>Health Net Health Plan of Oregon, Inc.</td>
<td>$25</td>
<td>$235</td>
<td>9.8%</td>
</tr>
<tr>
<td>Atrio Health Plan</td>
<td>$24</td>
<td>$330</td>
<td>6.9%</td>
</tr>
<tr>
<td>All carriers</td>
<td>$44</td>
<td>$260</td>
<td>13.6%</td>
</tr>
</tbody>
</table>

Primary care spending: What’s included?
To calculate the percentage of total medical spending allocated to primary care, the sum of claims-based and non-claims-based payments to primary providers is divided by the sum of total claims-based and non-claims-based payments to all providers (illustrated below). As the denominator, total include all payments for members including specialty care, mental health care, hospitalizations and more. However, total payments do not include drugs.

Claims-based payments for primary care + Non-claims-based payments for primary care = Percentage of medical spending allocated to primary care

Total claims-based payments + Total non-claims-based payments

Claims-based payments
Payments to primary care providers and practices:
- Primary care providers:
  - Physicians specializing in primary care, including family medicine, general medicine, obstetrics and gynecology, pediatrics, general psychiatry, and geriatric medicine
  - Naturopathic providers
  - Physicians’ assistants, and
  - Nurse practitioners

For primary care services:
- Office or home visits
- General medical exams
- Routine medical and child health exams
- Preventive medicine evaluation or counseling

Non-claims-based payments
Payments to primary care providers and practices:
- Primary care practices:
  - Primary care clinics
  - Federally qualified health centers (FQHCs), and
  - Rural health centers

- Health risk assessments
- Routine obstetric care, including delivery, and
- Other preventive medicine

The MN APCD is the most robust dataset in Minnesota, with more than 100 entities contributing data.

“This is eye-opening information for the purchasers of health care. Employers have long suspected that there is a great deal of variation in both the quality and the cost of health care, but to be able to see the actual numbers provides them an opportunity to make better purchasing decisions. Employers can also help employees and their family members identify and access more affordable care.”

Carolyn Pare MN Health Action Group
Reference-Based Inpatient and Outpatient Payment Analysis:
Reducing Payment Variation as a Potential Cost-Savings Mechanism

November 2018

Reference-based Pricing Estimates: CO

Research on Opioid Prescribing and Chronic Use: MN

Focuses on opioid prescription patterns among Minnesotans with private or public insurance coverage.

Explores:
- Opioid prescription trends by payer
- Patients’ diagnoses preceding a prescription opioid fill
- Number of prescribers
- Patients’ geographic location

Research on Low Value Services: VA

Focuses on identifying potentially unnecessary medical services using the MedInsight Health Waste Calculator methodology. Explores:

- Average and total costs of common low value services
- Comparison of overall low value spending by service

2016 Statewide Low Value Services Report - Overall

<table>
<thead>
<tr>
<th>Low Value Reason</th>
<th>Total Services Measured</th>
<th>Percentage of All Services Measured</th>
<th>Number of Individuals Receiving Service</th>
<th>Number of Individuals Receiving Low Value Service</th>
<th>% of Overall Low Value Spending</th>
<th>Total Prepay Cost of Low Value Service</th>
<th>Average Cost per Service</th>
<th>Per Member Per Month Low Value Spending</th>
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<td>Common Treatments</td>
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<td>Don’t order antibiotics for uncomplicated respiratory tract infections</td>
<td>20,160</td>
<td>6%</td>
<td>2,614</td>
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Average and total costs of common low value services

Comparison of overall low value spending by service
Focuses on providing cost estimates for common medical and dental procedures by medical provider or facility in New Hampshire.

Explores:
- Costs of procedures based on insurance provider
- Comparison of provider or facility quality of care
Research on Pharmacy Spending: MN

Focuses on understanding prescription drug spending for Minnesotans with insurance coverage

Explores:
- The role of medical claims and how they intersect with drug spending and pharmacy claims

Introduction

Prescription drugs offer important treatment options to providers and patients for addressing acute and chronic conditions. And, although many innovative prescription drugs confer substantial clinical and economic benefits to patients, the steady increase in prescription drug spending has resulted in greater interest by policy makers and other stakeholders in Minnesota and nationwide to better understand the underlying trend in the market for prescriptions.

As they consider key policy questions related to prescription drug coverage and purchasing strategies, stakeholders—including legislators, public and private purchasers, employers, pharmacy benefit managers, and consumers—historically have had limited information on Minnesota-specific spending trends and cost drivers across the entire spectrum of drug spending. Given the complexity of the prescription drug market and the overall scarcity of detailed data about it, prescription drug spending reports are often limited to assessments of spending in retail pharmacy settings, with little detail available on spending for prescription drugs in medical settings such as physicians’ offices, hospital outpatient clinics, and other health care facilities. Drug spending and use in these medical settings has been increasing substantially in recent years, contributing to growth in overall health care spending. Yet details about this trend, particularly at the state level, are not generally available.

Future issue briefs will further explore spending for and use of prescription drugs in Minnesota by:
- Groupings of drugs by their functions (therapeutic category);
- Whether they are brand, generic, or specialty drugs;
- Channels of distribution and payment;
- Groupings of type of prescribing providers; and
- Variations in spending, use, and cost by geographic location.

Key Findings

- Spending in 2013 on all prescription drugs for Minnesotans with insurance coverage captured in the MN APCD was about $7.4 billion.
- Prescription drugs spending in pharmacy and medical claims accounted for approximately 20 percent of total health care consumption that year.
- Between 2009 and 2013, prescription drug spending rose 20.6 percent, with medical claims accounting for more than one-half (55.1 percent) of this growth.
- The greater role of medical claims in drug spending, relative to pharmacy claims, is due to higher cost-
Focuses on the costs associated with potentially preventable visits to the ER in Rhode Island.

Explores:

- The potential cost savings that could be realized when preventing non-emergency visits to the ER

- The most common reasons for potentially preventable emergency room visits
Focuses on the most commonly diagnosed chronic conditions among insured Coloradans.

Explores:
- Chronic conditions in terms of geography, payer type, gender, and age
State APCDs are Evolving

State Collaboration for Solutions

ERISA
https://www.apcdcouncil.org/scotus-gobeille-v-liberty-mutual-insurance-company-decision

All Payer Claims Database-Common Data Layout (APCD-CDL™)
https://www.apcdcouncil.org/common-data-layout

SAMHSA 42 CFR-guidance to states

Non-claims Payments
Key Regulatory Issues Facing APCD States Post *Gobeille v. Liberty Mutual*

- **Enforceability**: APCD statutes are and remain, for the most part, enforceable.

- **Scope**: Generally, governmental plans are exempt from ERISA’s provisions and are not impacted by the *Gobeille* decision with regard to claims submission.

- **Voluntary reporting**: Who decides? ERISA does not address this situation. According to state regulators, most TPAs seem to be concluding that the plan sponsor (i.e., the employer) has the right to determine whether the TPA continues to voluntarily submit data.

- **HIPAA Privacy**: Claims data voluntarily submitted by self-funded ERISA plans would continue to comply with HIPAA privacy requirements notwithstanding the *Gobeille* decision.

- **Regulatory authority and APCD ‘savings’ from preemption**: The *Gobeille* decision did not address and does not alter a state’s authority to “regulate insurance.” The APCD requirements do not have to come from or be administered by the state department of insurance for the savings clause to apply.

- **What documentation is required to opt-out of the APCD?** States typically have the authority to request documentation or other verification of a plan sponsor’s decision to opt-out of (or opt-in to) APCD data submission.

  *Nothing about ERISA prevents submission of data- it only prevents states requiring submission*

These responses are not meant to provide legal advice and should not be relied upon as such. Instead, this is a compilation of opinions and regulatory interpretations that may help guide states as they assess the impact of the SCOTUS decision on APCD efforts.
APCD-CDL™ Purpose

The purpose of the Common Data Layout (CDL) for All-Payer Claims Databases (APCD-CDL™) is to harmonize the claims collection effort across states and reduce the burden of data submission. The overall goals of this effort are to improve efficiency, reduce administrative costs and improve accuracy in claims data collection.
Development process of the APCD-CDL™

• Co-ordinate a state response to Supreme Court decision in Gobeille v. Liberty Mutual

• Cross walked state APCD files for consistency and divergence
  – States had made efforts in the past to harmonize https://www.apcdcouncil.org/publication/history-apcd-council-harmonization-efforts

• Weekly calls from May 2016- March 2017 to review every proposed field with states, vendors and payers
  • October 2018 states requested NAHDO/APCD Council make APCD-CDL™ available
  • December 1 2018, APCD-CDL™ available by request https://www.apcdcouncil.org/sites/default/files/media/cdl_request_form_2018_0.pdf
  • APCD-CDL™ advisory committee developing a process for maintenance (Jan 2019-present)
Recommendations for Health Cost Control

Letter to The Honorable Lamar Alexander, Chair, HELP Committee

Create pathway to encourage development of APCDs

We recommend that the Department of Labor use its authority to create a standardized process that state APCDs could use to collect data from self-insured plans or that Congress amend ERISA to allow states to move ahead on their own.
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