

All-Payer Claims Databases: State Progress and Future of APCDs

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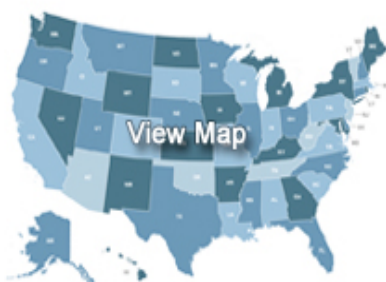


About NAHDO

- Established by the Washington Business Group on Health in 1986
- Expanding and improving hospital reporting systems
 - Founding states were first HCUP states
- As All Payer Claims Data Bases (APCDs) expanded, NAHDO partnered with the Regional All Payer Health Information Council (RAPHIC) → APCD Council
- Supports a national network of health care data experts
 - Transfer of best practices, methods, technologies across states

Interactive State Reports Map

Click on a state to find out about the APCD in that state.



States: As information about the APCD changes in your state, please contact ashley.peters@unh.edu, so that we can keep the state profiles current.

Welcome to the APCD Council!

The APCD Council, formerly known as the **Regional All Payer Healthcare Information Council (RAPHIC)**, is a federation of government, private, non-profit, and education organizations focused on improving the development and deployment of state-based all payer claims databases (APCD). The APCD Council is convened and coordinated by the **Institute of Health Policy and Practice (IHPP)** at the **University of New Hampshire (UNH)** and the **National Association of Health Data Organizations (NAHDO)**.

RAPHIC was first convened in 2006 by UNH, IHPP staff with the goal of engaging future users of the Maine and New Hampshire APCDs in a discussion about multi-state collaboration. Soon after, states across the country joined the group. Currently, there is participation from nearly a dozen states. NAHDO was established in 1986 to promote the uniformity and availability of health care data for cost quality and access purposes. In 2007, NAHDO forged a collaboration with RAPHIC to expand APCD data initiatives beyond the north east region and to lead fund raising for APCD products and conference support. Together, NAHDO and RAPHIC have been coordinating a multistate effort to support state APCD initiatives and shape state reporting systems to be capable of supporting a broad range of information needs.

In response to a shift from a regional to nationwide focus, RAPHIC has changed its name to the APCD Council. The APCD Council will continue to work in collaboration with states to promote uniformity and use of APCDs.

Backdrop 2005-2011

- Increased Transparency Efforts
- Employer Coalitions
- Payment Reform
 - Patient Centered Medical Home
 - Accountable Care Organizations
- Health Information Exchange (HITECH)
- Health Reform (PPACA)
- No data on outpatient care patterns

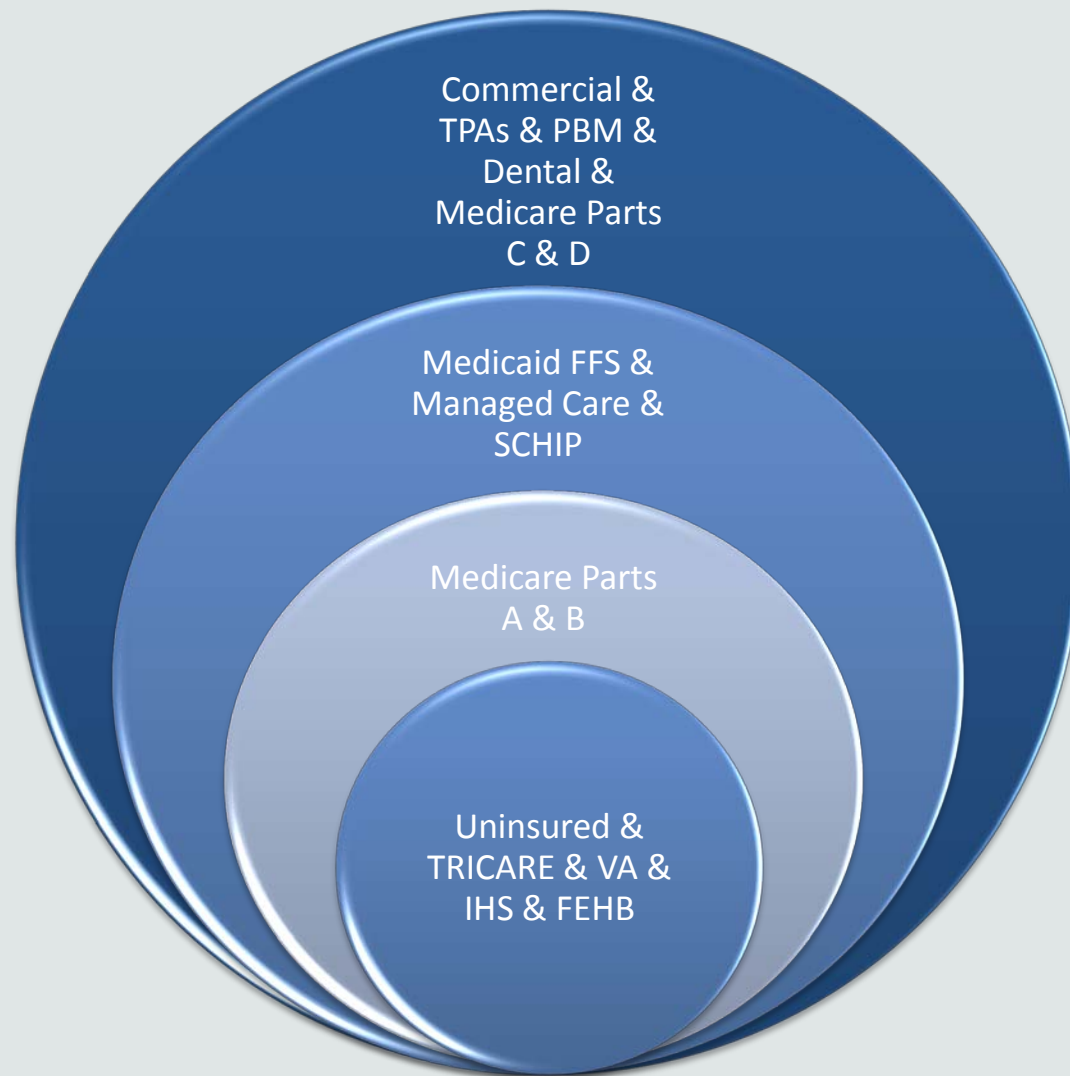
Definition of APCDs

- 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)
- *Augmenting (not replacing)* hospital discharge, Medicaid, Medicare, registries, and other datasets

APCDs lay the foundation for understanding payment/cost of APCDs contain system-wide data sources and inputs

- Administrative claims covering all categories of health care services
- All service categories
 - (e.g., inpatient, pharmacy, outpatient and professional)
- These emerging data systems provide states opportunities to apply a different unit of evaluation, such as an employer group, condition or community rather than a provider health care delivery system
- Potential for integration through HIEs, HBEs.

Sources of APCD Data



Typically Included Information

- Social Security Number
- 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)
- Employer group/ subgroup#
- Date paid
- Type of bill
- Facility type
- Other 835/837 fields

Typically Excluded Information

- Services provided to uninsured (few exceptions)
- Denied claims
- Workers' compensation claims
- Referrals
- Test results from lab work, imaging, etc.
- Provider affiliation with group practice
- Provider networks
- *Premium information*
- *Capitation fees*
- *Administrative fees*
- *Back end settlement amounts*
- *Back end P4P or PCMH payments*

National Activities and Standards

Data Standards Work Plan

- Collection Standards:
 - NCPDP (Pharmacy) state reporting guide
 - X12N Medical/Eligibility files in process
 - Dental (future)
- Data release varies by state
 - Legal environments differ
 - Stakeholder demands drive many policies

Usage Examples

APCD Users

- Consumers
- Employers
- Health Plans/Payers
- Providers
- Researchers (public policy, academic, etc.)
- State government (policy makers, Medicaid, public health, insurance department, etc.)
- TBD (Federal government, etc.)

APCDs Are About Transparency and Assessing Value

- What does a back MRI cost by provider by payer?
- What are the immediate opportunities to reduce variation, overuse, save money?
- What percentage of my employees have had preventive screenings? How do rates compare with total commercial market and inform benefit design?
- What are the disparities in care for various populations?
- What is the average length of time people are using antidepressant medications?
- What is the relationship between use and cost?
- Hundreds of additional questions have been asked....

APCDs and Improvement

- Targets set for collaborative community wide or employer population improvement
 - Decrease in PQI admissions (e.g. by 25%)
 - Decrease in readmissions (20% outside of index admission hospital)
 - Decrease in potentially avoidable ED use (e.g. by 15%)
 - Increase in care delivered in local communities
- Pre and post event tracking

Detailed estimates for Arthroscopic Knee Surgery (outpatient)

Procedure: [Arthroscopic Knee Surgery \(outpatient\)](#)

Insurance Plan: Anthem-HMO, Within 50 miles of 03301, Deductible and Coinsurance Amount: \$50.00 / 10%

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
SALEM SURGERY CENTER	\$363	\$2822	\$3185	HIGH	VERY LOW	603.898.3610
CONCORD HOSPITAL	\$383	\$3006	\$3389	MEDIUM	MEDIUM	603.228.7145
DARTMOUTH HITCHCOCK SOUTH	\$398	\$3135	\$3533	LOW	MEDIUM	603.650.5000
LAKES REGION GENERAL HOSPITAL	\$469	\$3776	\$4245	LOW	MEDIUM	603.527.7171
MARY HITCHCOCK MEMORIAL HOSPITAL	\$509	\$4135	\$4644	HIGH	MEDIUM	603.650.5000
SOUTHERN NH MEDICAL CENTER	\$522	\$4254	\$4776	MEDIUM	MEDIUM	603.577.2000
WENTWORTH DOUGLASS HOSPITAL	\$524	\$4266	\$4790	MEDIUM	HIGH	603.742.5252
PORTSMOUTH REGIONAL HOSPITAL - HCA AFFIL	\$548	\$4483	\$5031	MEDIUM	MEDIUM	603.436.5110
PORTSMOUTH AMBULATORY SURGERY CENTER	\$596	\$4918	\$5514	HIGH	MEDIUM	603.433.0941
ST JOSEPH HOSPITAL	\$619	\$5129	\$5748	HIGH	MEDIUM	603.882.3000
FRISBIE MEMORIAL HOSPITAL	\$670	\$5587	\$6257	MEDIUM	MEDIUM	
MONADNOCK COMMUNITY HOSPITAL	\$701	\$5867	\$6568	LOW	HIGH	603.924.7191
EXETER HOSPITAL	\$731	\$6131	\$6862	HIGH	MEDIUM	603.778.7311
FRANKLIN REGIONAL HOSPITAL	\$816	\$6898	\$7714	MEDIUM	MEDIUM	603.527.7171
NEW LONDON HOSPITAL	\$826	\$6988	\$7814	MEDIUM	VERY LOW	603.526.2911

Source: www.nhhealthcost.org

Pricing Difference by Carrier and Provider: Colonoscopy

FACILITY	ANTHEM	CIGNA	HARVARD
CHESHIRE MEDICAL CENTER	2,091.22	1,552.98	1,757.94
DARTMOUTH HITCHCOCK SOUTH	1,243.94	1,169.12	1,192.33
EXETER HOSPITAL	2,325.32	2,148.21	2,065.92
FRISBIE MEMORIAL HOSPITAL	1,658.53	1,200.62	1,431.43
PORTSMOUTH REGIONAL HOSPITAL	1,715.74	2,075.38	1,514.17
SPEARE MEMORIAL HOSPITAL	1,381.96	--	1,087.22
WENTWORTH DOUGLASS HOSPITAL	1,906.15	1,942.21	1,949.79

Source: www.nhhealthcost.org, Fall 2007

NH Carrier Discounts – 2009 Commercial

Aggregate Discounts (Below)

HMO Discounts by Carrier (Right)

- 1) Anthem – NH = 38.6%
- 2) Harvard Pilgrim Health Care = 38.5%
- 3) Connecticut General Life Insurance/Cigna = 32.9%
- 4) MVP = 30.4%
- 5) All other insurance = 20.5%

HMO – All Providers Included

Carrier	Observations	Average Discount	Lower CI	Upper CI
All Other Insurance	2,281	34.3%	33.4%	35.2%
CGLI/Cigna	11,079	34.1%	33.8%	34.5%
Anthem - NH	590,534	31.2%	31.2%	31.3%
Harvard Pilgrim HC	240,825	30.2%	30.1%	30.3%
MVP	303	30.1%	27.8%	32.5%

HMO – Hospitals Only

Carrier	Observations	Average Discount	Lower CI	Upper CI
Anthem - NH	106,527	38.6%	38.5%	38.8%
Harvard Pilgrim HC	48,330	36.0%	35.8%	36.1%
CGLI/Cigna	2,064	34.1%	33.5%	34.8%
MVP	69	22.4%	19.5%	25.4%
All Other Insurance	435	21.5%	20.1%	22.8%

HMO – No Hospitals

Carrier	Observations	Average Discount	Lower CI	Upper CI
All Other Insurance	1,846	37.3%	36.4%	38.3%
CGLI/Cigna	9,015	34.1%	33.7%	34.5%
MVP	234	32.4%	29.5%	35.2%
Anthem - NH	484,007	29.6%	29.5%	29.6%
Harvard Pilgrim HC	192,495	28.8%	28.7%	28.9%

Source: NH Insurance Department, January 28, 2010

Top Drugs by Therapeutic Class by Paid Amount 2009-2010

Therapeutic Class	2009		2010		PMPM Percent Change
	Total Cost	PMPM Cost	Total Cost	PMPM Cost	
Antidepressants	\$1,018,030	\$91	\$1,253,857	\$94	2.8%
Antihyperlipidemic Agents	\$866,514	\$115	\$1,089,322	\$127	9.4%
Proton Pump Inhibitors	\$757,566	\$211	\$811,354	\$195	(8.0%)
Cns Stimulants	\$552,953	\$190	\$779,371	\$204	6.8%
Sex Hormones	\$607,203	\$64	\$743,387	\$69	7.5%
Antidiabetic Agents	\$595,973	\$186	\$729,592	\$202	8.3%
Analgesics	\$599,848	\$71	\$593,199	\$62	(16%)
Immunosuppressive Monoclonal Antibodies	\$310,807	\$4,144	\$550,817	\$4,080	(1.6%)
Bronchodilators	\$477,051	\$147	\$541,940	\$153	3.6%
Dermatological Agents	\$303,467	\$89	\$371,602	\$87	(1.5%)
Anticonvulsants	\$326,883	\$80	\$326,487	\$64	(25%)
Interferons	\$280,646	\$6,527	\$322,900	\$8,073	19%
Antirheumatics	\$250,400	\$2,385	\$301,250	\$2,575	7.4%

Source: UNH

Top Drugs by Volume – 2009-2010

	2009	2010	
Drug Name	Total Fills	Total Fills	Volume Percent Change
Simvastatin	3,190	3,629	12%
Lisinopril	2,989	3,361	11%
Levothyroxine Sodium	2,612	3,007	13%
Acetaminophen-Hydrocodone Bitartrate	2,129	2,452	13%
Hydrochlorothiazide	1,937	2,298	16%
Sertraline Hydrochloride	1,647	2,035	19%
Amoxicillin	1,635	1,996	18%
Lipitor	1,671	1,933	14%
Citalopram Hydrobromide	1,474	1,850	20%
Metoprolol Succinate Er	1,441	1,715	16%
Fluoxetine Hydrochloride	1,292	1,645	21%
Lorazepam	1,208	1,641	26%
Lexapro	1,375	1,626	15%

Source: UNH

ETGs for Benign Conditions of the Uterus

Maine Commercial Claims (2006–2007); Full Episodes Outliers Removed
Preference Sensitive Care

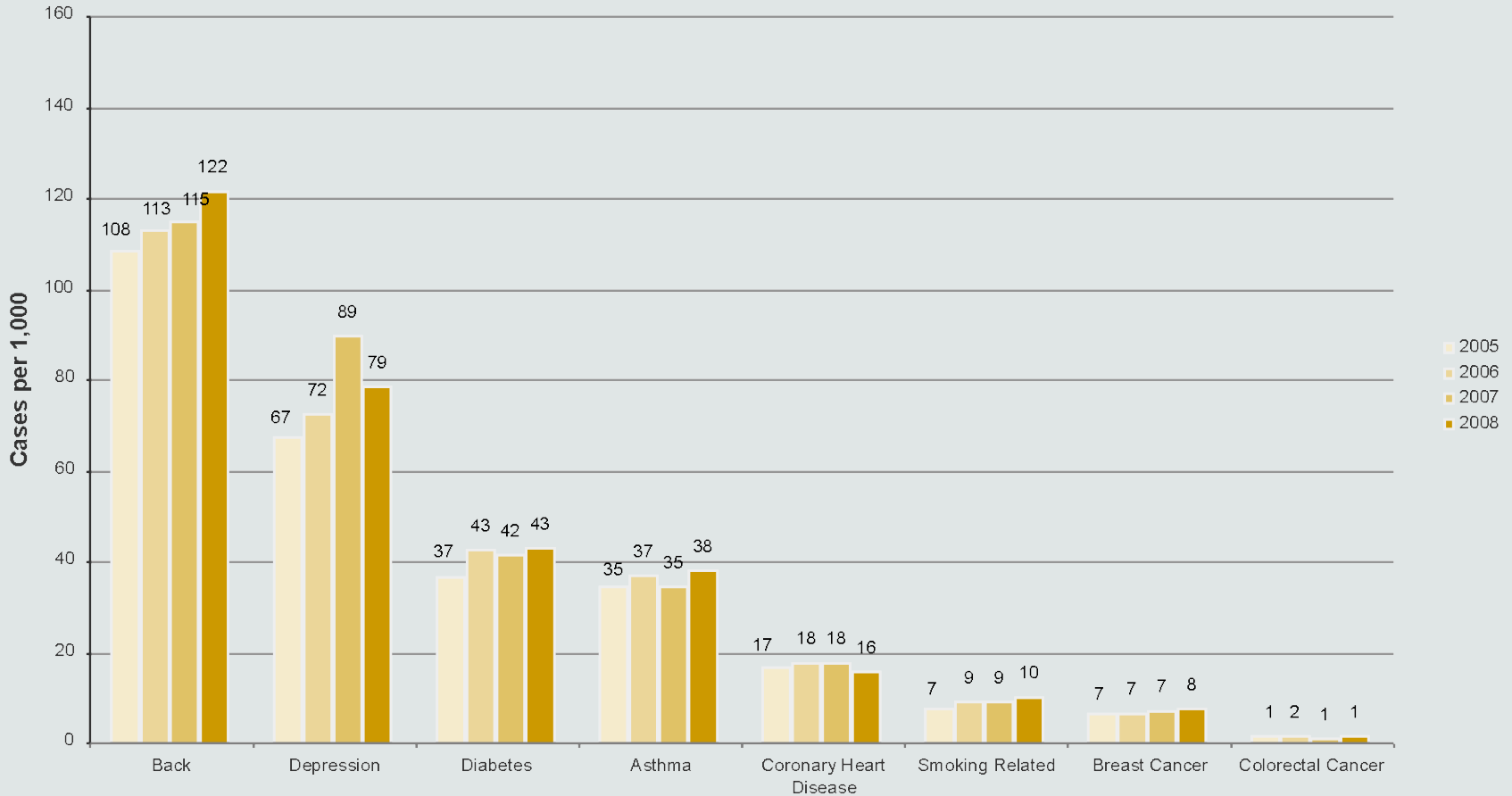
BENIGN CONDITIONS OF THE UTERUS	HYSTERECTOMY	OTHER SURGICAL PROCEDURES	WITHOUT SURGERY
ETG-Subclass	646	646	647
Number of Episodes	938	2,183	7,369
% with CT-Scan	11%	15%	9%
% with Ultrasound	57%	67%	45%
% with Hysteroscopy	7%	48%	9%
% with Colposcopy	1%	2%	17%
% with Endometrial biopsy	20%	13%	9%
Average Payment per Episode	\$11,074	\$7,994	\$1,273

The average episode payment for members with abdominal hysterectomy was \$11,221, and the average payment for members with vaginal hysterectomy was \$10,990. Of members with a hysterectomy, 66% had abdominal and 34% had vaginal hysterectomy. Other surgical procedures included hysteroscopy ablation, laparoscopic removal of lesions, myomectomy, and removal of ovarian cysts.

SOURCE: ONPOINT HEALTH DATA

Prevalence of Selected Conditions

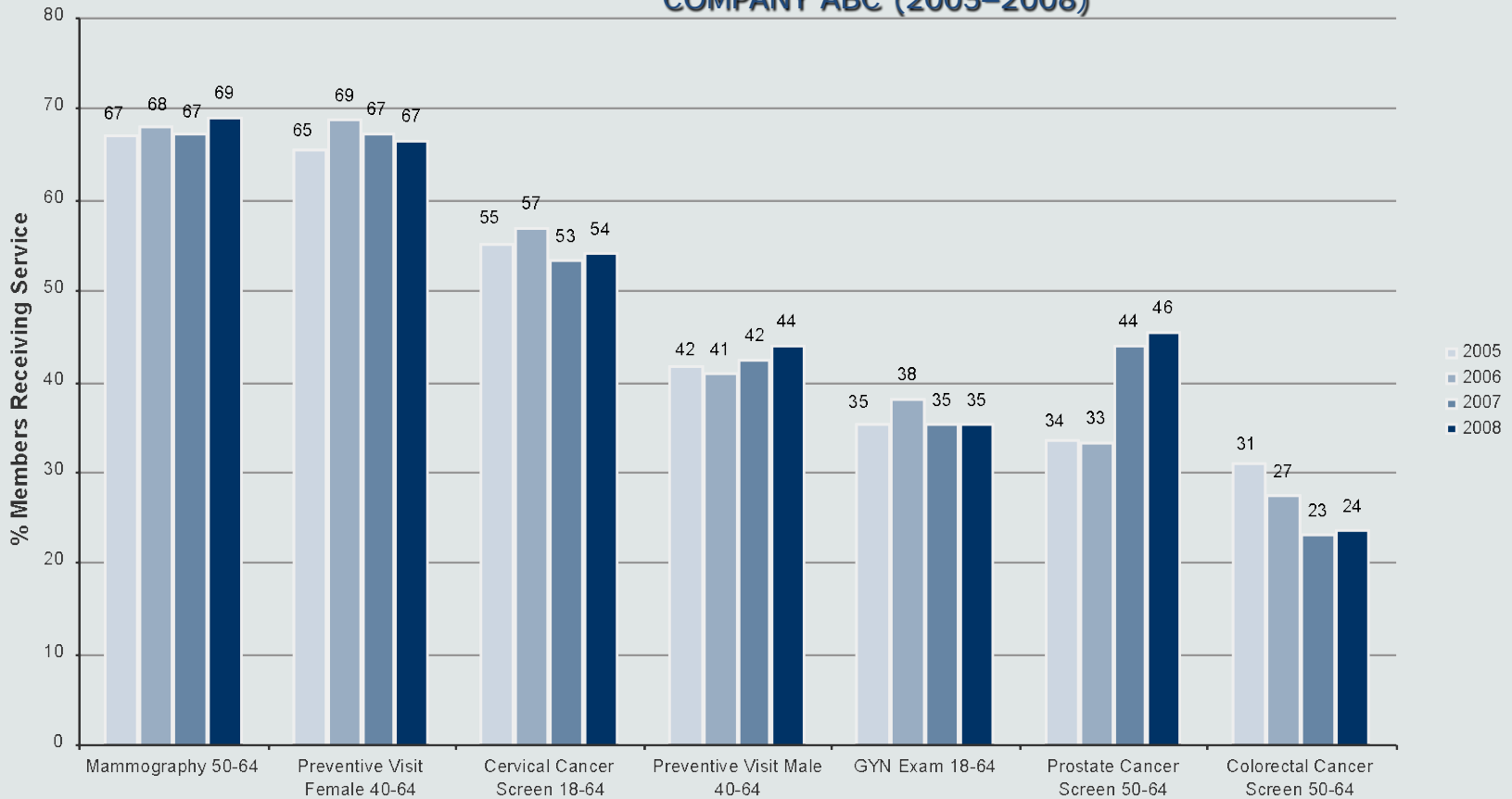
COMPANY ABC (2005–2008)



SOURCE: NHPGH

Percent Members Receiving Preventive Services

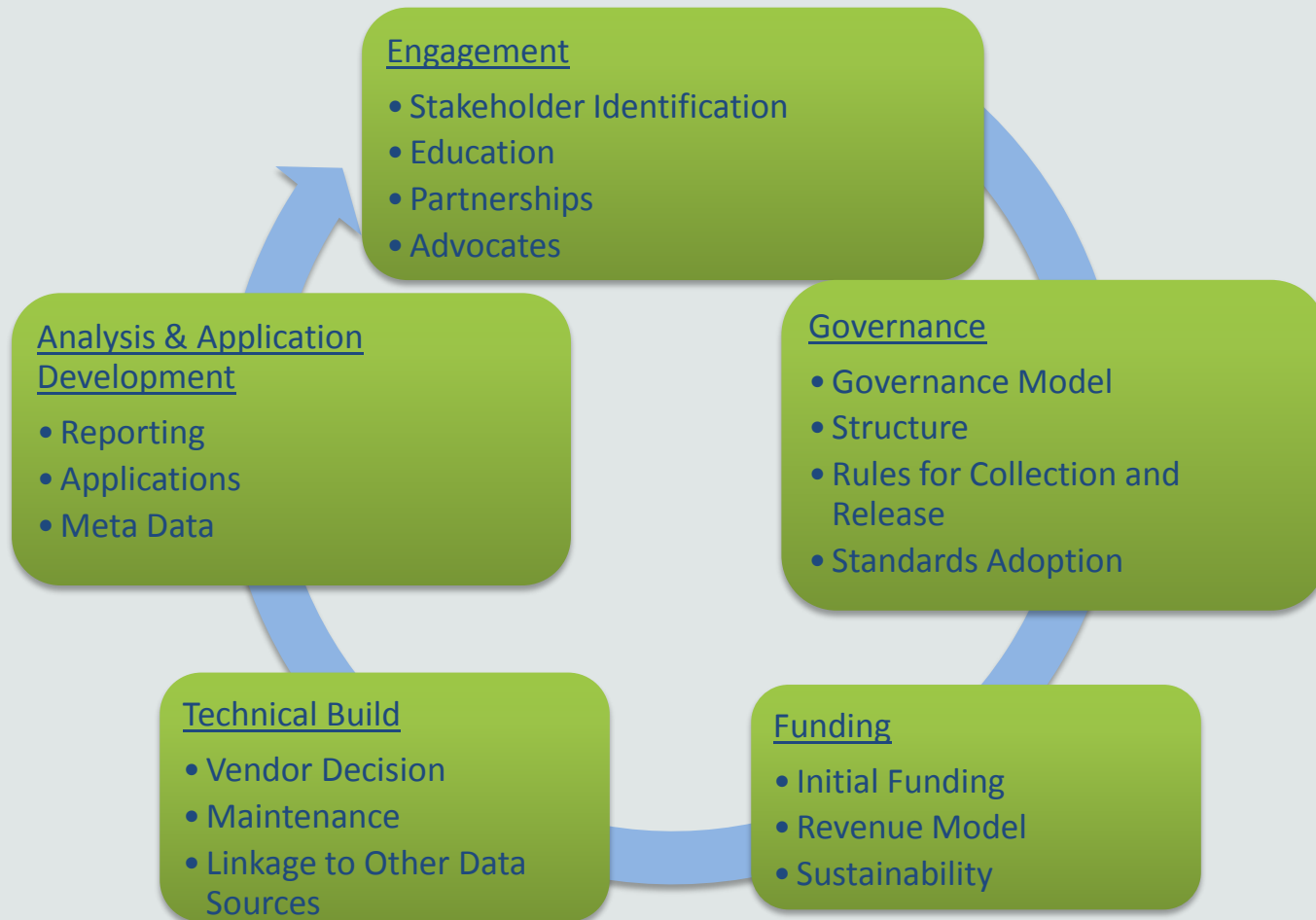
COMPANY ABC (2005–2008)



SOURCE: NHPGH

Experiences and Lessons Learned

All-Payer Road Map



Funding Models

- General Funds
- Assessments (payers, providers)
- Medicaid (various options)
- Private Foundations
- Data Sales (minimal)
- Grants: federal, state, private
- Products/Services: Data aggregation/reporting for required HEDIS activities
- Products/Services: Data aggregation/reporting for P4P programs
- Beacon Community Grant

Lessons Learned (synthesis of roundtable discussions, NAHDO Conference, Nov. 2011)

- APCDs permit states to “connect the dots”
- Local changes driven by local data and stakeholders
- For some conditions, like C/S, cost, not quality varies
- Statewide implementation takes time---and long-term support
- How to fund APCDs that benefit the public??
- Seize Integration & Linkage Opportunities
- **Local stakeholders matter (e.g. funding, collection of identifiers, and data access reflect who is engaged)**
- Need for standardized measures
 - Quality metrics/tools not as well-vetted as cost measures

Questions and Answers

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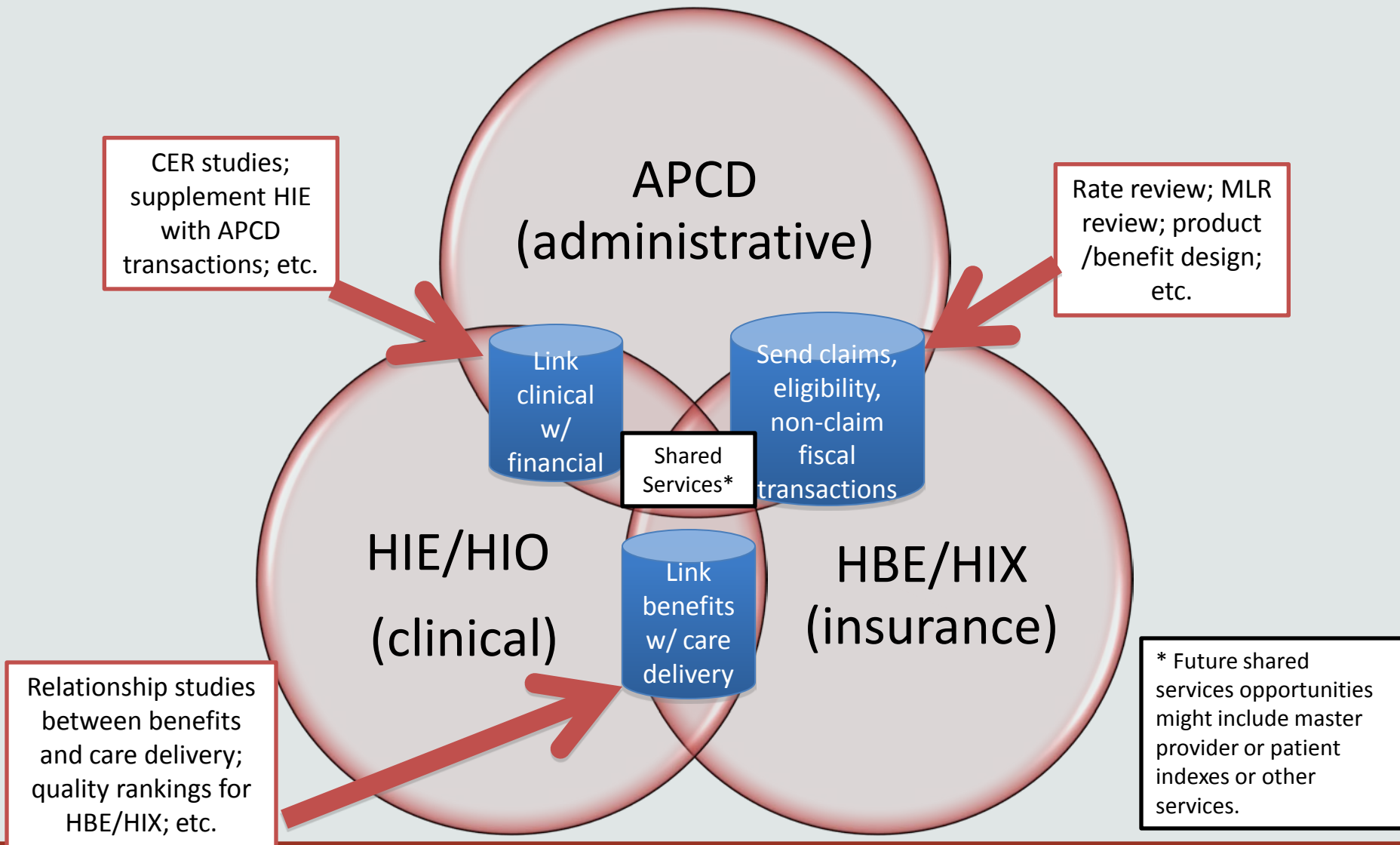
www.apcdouncil.org

Appendix: APCD 2.0

APCD 2.0

- Completeness of Data Sets
- Data Collection Standards
- Data Release Standards
- Collection of Direct Patient Identifiers for Linkage Purposes
- Collection of Premium Information
- Collection of Supplemental Financial File
- Collection of Benefits Information
- Master Provider Index

Linkage Opportunities



Status by State of Direct Patient Identifier Collection

State	Status
Colorado	Based upon an initial 2011 report to Governor and General Assembly, all data transmitted from the carriers, including patient identifiers will be encrypted during transmission and while stored within the APCD. Data will be decrypted briefly as received from the carriers so that a unique identifier can be attached to each patient, and then re-encrypted. All data will be released without direct patient identifiers.
Kansas	Not currently allowed for commercial data, but due to the HBE, Kansas expects that within six months there will be an effort to change this. Kansas currently collects identifiable information for state employees and Medicaid.
Maine	Allowed by law, but prohibited by law from being disclosed; not currently collected. A 2011 legislative proposal intended to allow for release did not pass, but will be evaluated under a legislative study.
Maryland	Allowed by law. Currently collecting unencrypted patient identifiers.
Massachusetts	Allowed by law. Currently collecting unencrypted patient identifiers.
Minnesota	Not currently allowed.
New Hampshire	Not currently allowed.
New York	Allowed by law. System not implemented yet.
Oregon	Currently collecting a subset of unencrypted patient identifiers.
Rhode Island	Not currently allowed.
Tennessee	Not currently allowed.
Utah	Allowed by law. Currently collecting unencrypted patient identifiers.
Vermont	Allowed by law. Currently collecting encrypted patient identifiers.
West Virginia	Allowed by law to be collected, but not disclosed.