

APCD Year in Review 2016

APCD All-Payer
Claims Database
COUNCIL SM



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Policy and Practice**

Activity at the State Level

States have been busy using the data!

July 2016	<u>CIVHC Utilization Spot Analysis: Free Standing Emergency Departments</u>
July 2016	<u>Oregon Hospital Payment Report 2014</u>
June 2016	<u>Utah Health Status Update: Using Clinical Risk Groups to Analyze the Utah All Payer Claims Data</u>
June 2016	<u>Spending and Use Among Maryland's Privately Fully Insured</u>
May 2016	<u>A Snapshot of Hepatitis C in Colorado</u>
May 2016	<u>Green Mountain Care Board Price Variation Analysis</u>
April 2016	<u>Vermont's Community-Oriented All-Payer Medical Home Model Reduces Expenditures and Utilization While Delivering High-Quality Care</u>
February 2016	Rhode Island <u>Potentially Preventable Emergency Room Visits</u>
February 2016	Colorado <u>Cost Driver Spot Analysis: Payment Variation by Payer</u>
January 2016	<u>Chronic Conditions in Minnesota: New Estimates of Prevalence, Cost and Geographic Variation for Insured Minnesotans, 2012</u>
May 2016	MassHealth Baseline Statistics – May 2016
July 2016	MA Enrollment Trends Report – July 2016
October 2016	Annual Report on the Performance of the Massachusetts Health Care System
March 2016	MN public use files
June 2016	NH HealthCost update
June 2016	CompareMaine update




CHRONIC CONDITIONS IN MINNESOTA: New Estimates of Prevalence, Cost and Geographic Variation for Insured Minnesotans, 2012

MINAPCD
All Payer Claims Database

JANUARY 2016

MDH Minnesota Department of Health

Minnesota Department of Health | 1000
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55403 | 612.232.1000 | www.health.state.mn.us



Utah Health Status Update:
Healthcare Cost in Utah: Brief Summary of the 2014 Utah All Payer Claims Data

Special Edition 1
January 2016


The Utah Legislature granted authority to the Utah Department of Health (UDOH) and the Utah Health Data Committee to collect data from healthcare payers with an enrollment of 2,500 or more covered lives and create the Utah All Payer Claims Database (APCD). Utah's APCD collects medical, pharmacy, and dental claims data from both private and government payers, including Medicaid and some Medicare Advantage and federal employee health plans. There are a total of 37 APCD data suppliers, representing roughly 80% of the Utah population.

KEY FINDINGS

- Utah's APCD collects medical, pharmacy, and dental claims data from both private and government payers.
- Utah APCD's primary objective is to increase cost and quality transparency in our healthcare markets.
- In 2014, the total healthcare payments reported to the APCD for patients under age 65 exceeded \$6.8 billion in Utah.
- Nearly half (47%) of the payments went to inpatient and outpatient facilities.
- Utah insurance carriers and their members paid, on average, about \$3,188 per person for medical and pharmacy claims in 2014.
- Two new 2013-14 limited datasets are now available to authorized users from the APCD. For more information, visit <http://health.utah.gov/data>.

Total Paid Amount by Claim Type, Utah, 2014

Figure 1. Total payments by claim type for persons under age 65 in Utah, 2014.



APCDs are comprehensive, longitudinal, multi-payer datasets capable of providing unprecedented research and policy opportunities for improving the healthcare delivery system. Utah APCD's primary objective is to increase cost and quality transparency in our healthcare markets.

Based on newly available data, we present the basic summary information as follows:

Table 1 presents information on the four primary types of health claims payments made in 2014 and reported to the APCD for under age 65. Total healthcare payments exceeded \$6.8 billion with liability making up 15% of total payments. Nearly half of the payments went to inpatient and outpatient facilities. In terms of pharmacy claims accounted for 47% of all claims.

Per-Person-Per-Year Healthcare Cost, Under Age 65

For the first time, the APCD enabled the UDOH to calculate Per-Person-Per-Year (PPPY) healthcare costs for the state of Utah. Under age 65, on average, per person for medical and pharmacy claims in 2014 was \$3,188.

Total Payments and Member Liability

Table 2. Payments of healthcare claims for persons under age 65 in Utah, 2014.

Claim Type by Site of Service	Plan Paid Amount	Member Paid Amount	Total Paid Amount	Member Liability as % of Total
Inpatient Facility	\$ 1,944,857,215	\$ 381,332,704	\$ 2,326,189,919	6.8%
Outpatient Facility	\$ 1,907,215,825	\$ 288,225,996	\$ 2,195,441,821	17.1%
Pharmacy	\$ 951,794,966	\$ 85,174,624	\$ 1,036,969,590	10.3%
Professional	\$ 2,037,595,847	\$ 452,686,310	\$ 2,526,362,166	17.9%
All	\$ 6,844,863,406	\$ 1,117,419,635	\$ 7,962,283,041	15.0%

UDOH
Utah Department of Health

POPULATION HEALTH MANAGEMENT
Volume 19, Number 1, 2016
Mary Ann Liebert, Inc.
DOI: 10.1089/pop.2015.0005

Vermont's Community-Oriented All-Payer Medical Home Model Reduces Expenditures and Utilization While Delivering High-Quality Care

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Abstract

Patient-centered medical home programs using different design and implementation strategies are being tested across the United States, and the impact of these programs on outcomes for a general population remains unclear. Vermont has pursued a state-wide all-payer program wherein medical home practices are supported with additional staffing from a locally organized shared resource, the community health team. Using a 6-year, sequential, cross-sectional methodology, this study reviewed resources, the community health team, and quality outcomes for 123 practices participating in the program as of December 2013 versus a comparison population from each year attributed to nonparticipating practices. Populations are grouped based on their practices' stage of participation in a calendar year (Pre-Year, Implementation Year, Steady State Year, Post-Year 1, Post-Year 2). Annual risk-adjusted total expenditures per capita of Pre-Year for the participant group and comparison group were not significantly different. The difference-in-differences change from Pre-Year to Post-Year 2 indicated that the participant group's expenditures were reduced by -\$482 relative to the comparison (95% CI, -\$573 to -\$391; $P < .001$). The lower costs were driven primarily by inpatient and outpatient hospital expenditures (~\$154; $P < .001$), with associated changes in inpatient and outpatient hospital utilization. Medicaid participants also had a relative increase in expenditures for dental, social, and community-based support services (\$57; $P < .001$). Participants maintained higher rates on 9 of 11 effective and preventive care measures. These results suggest that Vermont's community-oriented medical home model is associated with improved outcomes for a general population at lower expenditures and utilization. (Population Health Management 2016;19:196-205)

Introduction

IMPROVING HEALTH CARE COSTS without compromising care quality and population-level health outcomes have led many states to pursue a variety of health care reforms. Vermont has pursued a coordinated statewide transition of primary care practices to National Committee for Quality Assurance (NCQA)-recognized patient-centered medical homes (PCMHs), augmentation of medical centers with multidisciplinary staff from community health centers (CHCs), and coordinated funding support from both private and public payers.¹ The goals were better control over growth in medical expenditures, a reduction in unnecessary hospital care, and improved quality of care across the population. The program is designed to achieve these goals through local leadership and regulation; consistent statewide quality standards (ie, NCQA PCMH standards); consistent measurement of performance against those standards; close coordination between primary care, CHC staff, and community-based services; and an emphasis on preventive, improved control of established health problems, and healthier lifestyles.

Description of the Program for Health

Launched in 2003 as a Governor's initiative, the Blueprint for Health's (Blueprint) initial aim was to improve care across the state's (Vermont's) health system. The Blueprint was a collaborative effort between the Vermont Department of Health, the Vermont State Office of Health, and the Vermont State Office of Health. The Blueprint was a collaborative effort between the Vermont Department of Health, the Vermont State Office of Health, and the Vermont State Office of Health.

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PERFORMANCE OF THE MASSACHUSETTS HEALTH CARE SYSTEM ANNUAL REPORT SEPTEMBER 2016



MASSHEALTH BASELINE STATISTICS FROM THE MA APCD

FFS & PCC PLAN
(FY2013 – FY2014)

MAY 2016



Cost Driver Spot Analysis: Payment Variation by Payer February 2016



Some Coloradans Pay Significantly More than Medicare for the Same Service
Commercial insurers pay more for hip and knee replacement surgery on average by 22% higher, or \$11,851 more than Medicare.

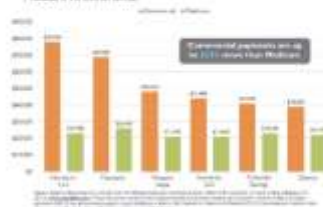
Recent national studies have revealed little to no correlation between Medicare and commercial payer health care spending in the same region. In particular, areas like Grand Junction, Colorado, historically penalized for their low cost to treat Medicare populations, have seen rates recent, resulting in higher than average commercial health care costs relative to other areas in the state and nation.

Outspenders in health care spending across payers have led to inquiries regarding the drivers of cost variation between the public and private sector.

The Colorado All Payer Claims Database (CO-APCD) provides a unique opportunity to analyze payments for specific services by payer type and identify areas of cost savings potential.

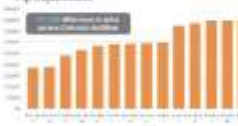
Price variation for hip and knee joint replacement in particular pay became a major focus for Medicare, which is using its mature spending and improving quality by paying hospitals one "bundled" price for the entire episode of care (e.g., the surgical procedure and all pre-surgery care up to 90 days).

Colorado Hip/Knee Replacement Average Total Episode Payments: Medicare vs. Commercial



Joint replacement are not a Medicare issue alone as over 12 million people across the U.S. in 2014 had a knee replacement or a total or partial hip replacement resulting in \$10 billion in costs to the health care system. The cost of a knee replacement for commercially insured Coloradans varies from \$15,000 - \$45,000 while hip replacement costs can be as low as \$18,000 or as high as \$40,000 across Colorado hospitals.

Median Total Price Commercially Insured Hip Replacement



Median Total Price Commercially Insured Knee Replacement



Median episode payments for hip and knee replacement are higher than the national average. The CO-APCD data shows that commercial payers are paying more for hip and knee replacement surgery than Medicare.

SPENDING AND USE AMONG MARYLAND'S PRIVATELY FULLY INSURED



Highlights: Spending and Use in Maryland

- Individual Market**
 - Total members (enrolled) as of December 31, 2014, in the individual market increased by about 20 percent.
 - The member per month (PMPM) spending in the individual market for all services increased between 2013 and 2014 by about 31 percent, mainly due to increased use of services. Utilization per 1,000 members increased for all service categories, ranging from 16 percent for professional services to 51 percent for prescription drugs.
 - In spite of increases in PMPM spending in the individual market, this market continued to have the lowest PMPM spending across all markets; however, the PMPM portion for services increased by 37 percent, while the out-of-pocket (OOP) PMPM for members increased by 19 percent. This difference resulted in a decrease (29 percent) in the members' OOP share of total spending in 2014. However, OOP spending remained the highest in the individual market compared with the other markets (small employer and large employer).
 - The median expenditure risk score increased from 0.09 to 0.20 between 2013 and 2014, indicating that new members entering this market in 2014 were likely sicker, as expected, resulting more care, which increased PMPM spending.
- Small Employer and Large Employer Markets**
 - PMPM spending for all services combined remained unchanged between 2013 and 2014 for large employers, but declined for small employers.
 - PMPM spending for inpatient services decreased in both the small employer and the large employer markets, but increased in the individual market.
- Access Markets**
 - Unit costs for all service categories increased in 2014, except for inpatient facility services, in which unit costs declined across all markets in 2014. This decrease in unit costs for inpatient facility services likely resulted from the State's new hospital global budget program initiated in 2015.

Regional health care costs are high due to a number of factors, including high rates of hospitalization, high rates of emergency department use, and high rates of hospitalization. Maryland's health care costs are high due to a number of factors, including high rates of hospitalization, high rates of emergency department use, and high rates of hospitalization.

BACKGROUND

This Spotlight examines health care spending and utilization patterns for Maryland residents covered through the individual, small employer, and large employer markets. The analysis relies on 2013 and 2014 data from Maryland's Medical Care Database (MCD), which contains health care claims and encounter data submitted

Potentially Preventable Emergency Room Visits

Introduction

A potentially preventable emergency room visit is when a patient goes to an emergency room for a health condition that could have been treated in a non-emergency setting or prevented by keeping them healthier earlier on. Treatment in an emergency room is generally more expensive than a primary care visit. When people have fewer barriers to good health in their communities, and when they can easily access high quality primary care and follow-up, they are less likely to end up in the emergency room. (Patients experiencing a medical emergency should always seek emergency care.)

Key Findings

In Rhode Island, we could potentially save \$30 million annually by preventing non-emergency visits to emergency rooms.

Chest pain is one of the top reasons for potentially preventable emergency room visits, and the most expensive. Better access to primary care and disease management could help prevent these visits.

Upper respiratory infections, low back, and abdominal pain are common, potentially preventable reasons Rhode Islanders go to the emergency room.



Legislative Activity

- **Florida** – HB1175 was signed by Gov. Rick Scott on April 14th and went into effect on July 1, 2016.
- **Delaware** - Senate Bill 238 was signed by Gov. Jack Markell on July 21, 2016.

Presentation to
DOH

Presentation
to Legislature

Support system
implementation

Contract to help
develop a plan

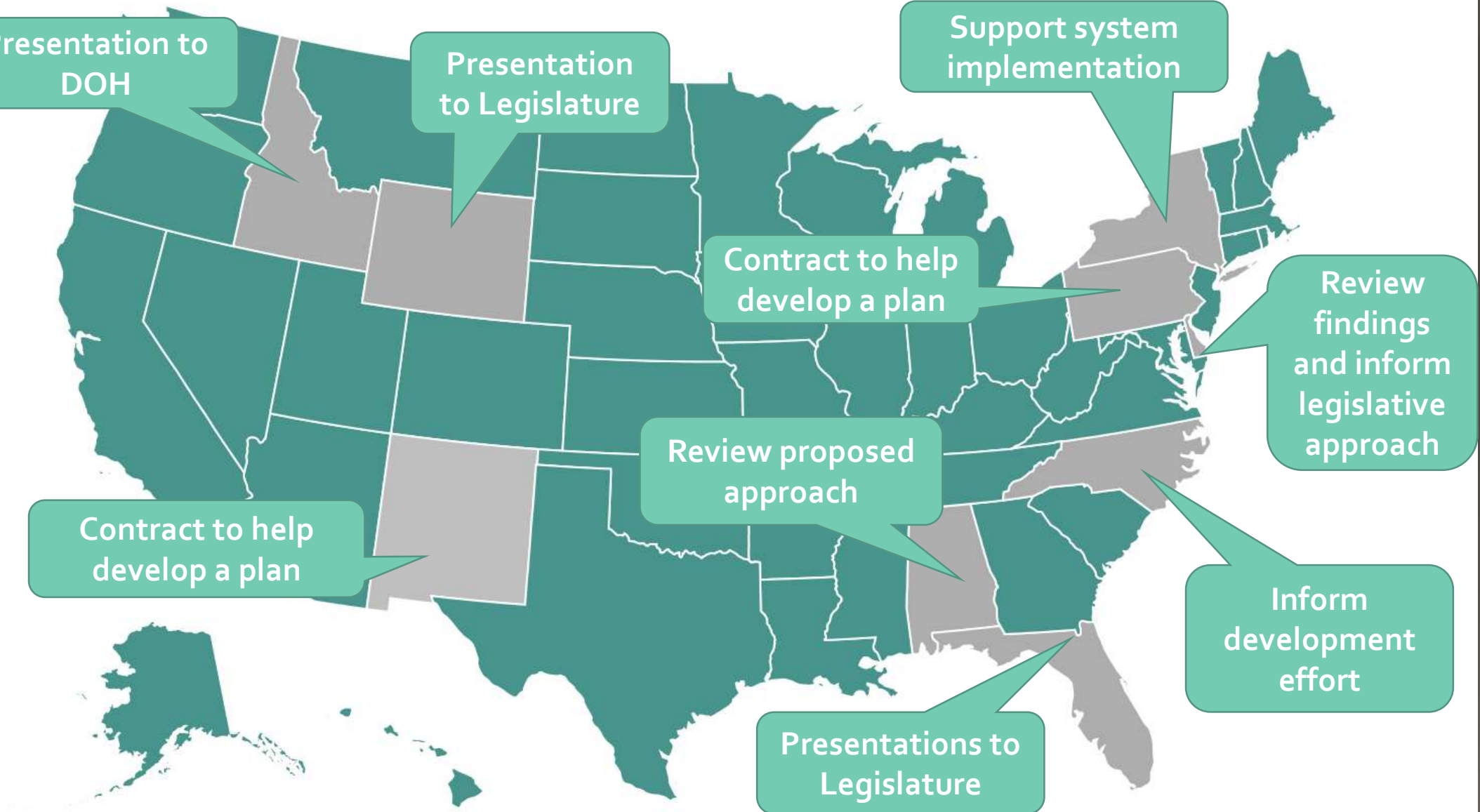
Review
findings
and inform
legislative
approach

Review proposed
approach

Contract to help
develop a plan

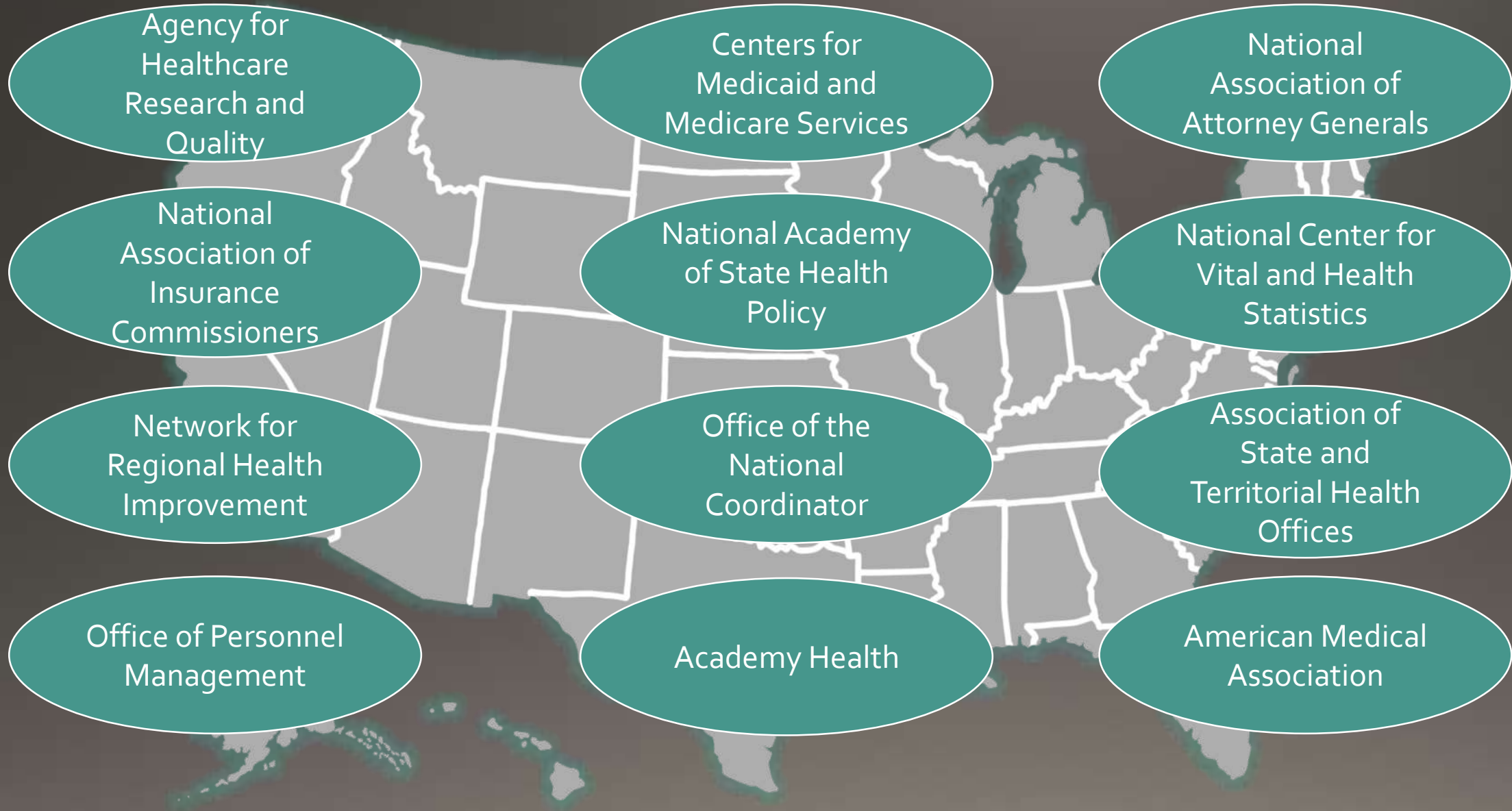
Inform
development
effort

Presentations to
Legislature

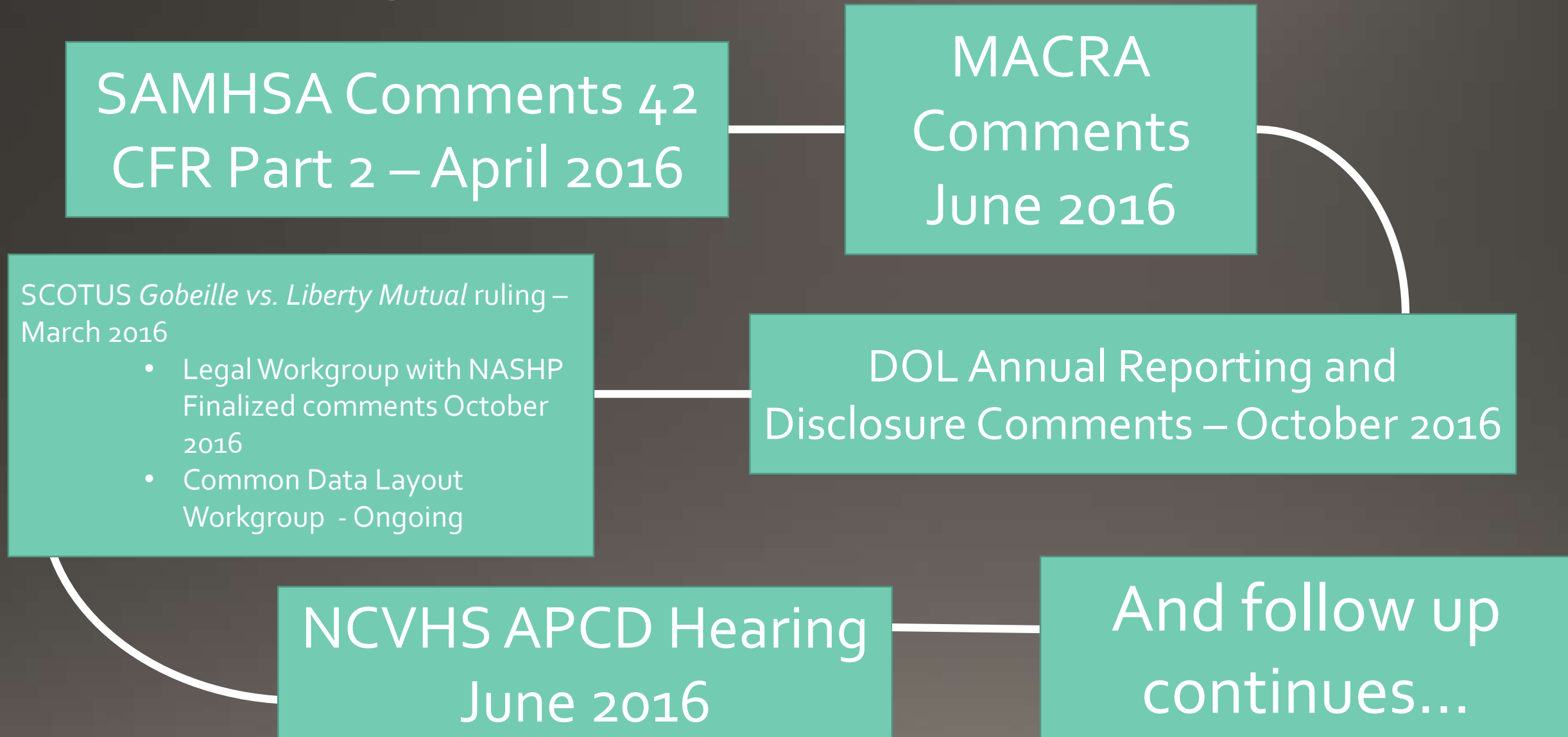


Activity at the National Level

Conversations at the National Level



Responding to key issues



The Value of All-Payer Claims Databases for Employers

What are All-Payer Claims Databases (APCDs)?

APCDs are databases, typically created by a state mandate, that generally include data derived from medical claims, pharmacy claims, eligibility files, provider (physician and facility) files, and dental claims from private and public payers. Data are submitted directly from health insurers, third-party administrators, and pharmacy benefit managers.

Why have APCDs been developed?

States have established state-sponsored APCD systems to fill critical information gaps needed to make effective health policy decisions, to support health care and payment reform initiatives, and to address the need for transparency in health care. States with APCDs are responding to a need for comprehensive, multi-payer data that allows a variety of health care stakeholders – including employers – to understand the cost, quality, and utilization of health care.

Why are APCDs important for employers?

The health of employees is of paramount importance for employers; helping employees stay healthy is a goal for wellness and productivity in the workplace. In addition, one of the most important issues for employers is controlling health care costs. A recent article from *Castlight Health* summarized the issue this way:

"Rising healthcare costs place a huge strain on business. According to a new *Bain & Co.* report, which consisted of more than 180 CFOs at large self-insured U.S. companies, 80% say they feel powerless when it comes to managing their company's healthcare spending. Even more so, 98% agree that if their company's healthcare costs were lower, they could afford to invest more in their businesses."¹

Health system performance improvement requires the availability of comprehensive local data. Employers often seek more information to understand the quality of care their employees receive, how much variation there is in health care costs, and what opportunities exist to improve the health and health care of their employees. Given the importance of health, health care, health insurance, and health policy to business, many employers are interested in making data-driven decisions for themselves and in the states in which they do business. APCDs can serve this purpose.

The examples below illustrate the ways state APCD data are used to support needs of importance to employers.

State and Regional Benchmarking

Employers contribute significant amounts of money, often over \$10,000 per employee, in premiums for health insurance.² Given this level of investment, employers are actively engaged in understanding health care cost and utilization. While some employers have access to data about the health and health care of their own employees through their insurance companies, third-party administrators, or other contractors, many businesses lack any information to which they can compare, or benchmark, their own experience. Many state APCDs have state and regional reporting that provide a basis for comparison, providing comparisons that employers often lack. Examples include:



Key Regulatory Issues Facing APCD States Post *Gobeille v. Liberty Mutual*

The All-Payer Claims Database (APCD) Council has collected and compiled responses to key questions posed to regulators in APCD states since the March 1 decision by the Supreme Court of the United States (SCOTUS) in *Gobeille v. Liberty Mutual*, related to key regulatory enforcement issues to be considered by states.

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.

REGULATORY ENFORCEMENT ISSUES FOR APCD STATES

Issue 1: Are state APCD statutes still enforceable?

Yes. APCD statutes are and remain, for the most part, enforceable. Health insurance companies, providers, government health plans, and other APCD-regulated entities are still authorized to comply with APCD reporting statutes. Unless specifically directed by self-funded plan sponsors otherwise, Third-Party Administrators (TPA) should also continue to comply with state APCD reporting requirements.

In *Gobeille v. Liberty Mutual*, a self-funded plan sponsor (employer) challenged the state of Vermont's right to compel the employer's TPA to submit claims data to the state's APCD regulated by the Green Mountain Care Board. In its March 1, 2016 decision, SCOTUS confirmed that Vermont's statute, as applied to the self-funded employer's Employee Retirement Income Security Act of 1974 (ERISA) plan, was preempted by ERISA.

Health insurance companies and TPAs have questioned the breadth of the *Gobeille* decision. In light of the facts giving rise to the decision, legal scholars agree that states can continue to require the submission of claims data from regulated health insurance covers, including fully insured plans; non-ERISA plans; and TPAs, as long as self-funded employer plans governed by ERISA have the opportunity to decide whether or not to submit their data.

Given the ruling, employers who offer self-funded ERISA plans may inform their TPA or the APCD that they decline to submit their data, and the state must comply with such a refusal.

Issue 2: Are governmental plans or other plans exempt from ERISA?

Generally, governmental plans are exempt from ERISA's provisions and are not impacted by the *Gobeille* decision with regard to claims submissions. ERISA defines a governmental plan as "a plan established or maintained for its employees by the Government of the United States, by the government of any State or political subdivision thereof, or by any agency or

Calendar 2015 - 2016

*Events, Conferences,
And Where the Conversations
are Happening*

November 2015

State-University Partnership
Learning Network Annual Meeting
19th & 20th
Washington, DC

December 2015

SCOTUS Oral Arguments
The 2nd
Washington, DC

January 2015

Improving Cost Transparency
and Quality of Care: Making All
Payer Claims Databases
(APCDs) Work for You
The 11th
Webinar

March 2016

State Healthcare IT Connect
Summit
21st & 22nd
Baltimore, MD

June 2016

NCVHS Claims Database Hearing
16th & 17th
Washington, DC

June 2016

Health IT Summit
The 24th
Boston, MA

July 2016

American Heart Association
Corporate Forum Policy Dialogue
The 28th
Washington, DC

July 2016

*Healthcare Measurement and APCDs:
Creating an APCD Measure Inventory
and Lessons for the Future of APCD
Measure Development*

*The 20th
Webinar*

October 2016

*NASHP Conference
17th, 18th & 19th
Pittsburgh, PA*

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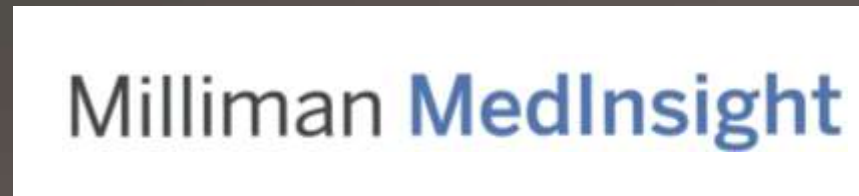
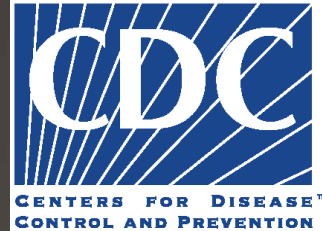


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