APCD Year in Review 2016







Institute for Health Policy and Practice

Activity atthe State Level

States have been busy using the data!

July 2016	CIVHC Utilization Spot Analysis: Free Standing Emergency Departments
July 2016	Oregon Hospital Payment Report 2014
June 2016	Utah Health Status Update: Using Clinical Risk Groups to Analyze the Utah All Payer Claims Data
June 2016	Spending and Use Among Maryland's Privately Fully Insured
May 2016	A Snapshot of Hepatitis C in Colorado
May 2016	Green Mountain Care Board Price Variation Analysis
April 2016	Vermont's Community-Oriented All-Payer Medical Home Model Reduces Expenditures and Utilization While Delivering High-Quality Care
February 2016	Rhode Island Potentially Preventable Emergency Room Visits
February 2016	Colorado Cost Driver Spot Analysis: Payment Variation by Payer
January 2016	Chronic Conditions in Minnesota: New Estimates of Prevalence, Cost and Geographic Variation for Insured Minnesotans, 2012
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
June2016	CompareMaine update



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

Special Editor 1

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Total Paid Amount by Claim Type, Utah, 2014 Special Virging represent the object opposition presents under against in Chapter 2014 Security States and April

providing enpresedented research and policy apportunities for improving the health care delivery execut." Usel: API, Theprimary objective inc includes and and quickly insuganticity active leads one module.

though our neight another than we proved the hard entertaint pollution.

Yable 1 process references on the four procesy types of health-asclaims payments made to 2014 and regioned to the APCD to pattern under age 65. Total healthcare payments incoded 86.0 total contribution patient liability making up (40) of total powerests. Nearly half of the plant purprints were to repain and indparting facilities. In terms of siderar pharmacy claims accounted for 17% of all charms

Yer-Person-Ser-Year Healthcare Cost, Under Age 67.

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time and their counters paid. on switzer, about \$5,786 per mary olders in 2014. As went is Figure 2, there expenses were divided by agenting services (8697, 1270), respected services

Utilization Spot Analysis: Free Standing Emergency Departments



From Standing Energency Departments (PSED) are disagreed to provide varies levels of amorganity out to as their hospital-based ED counterparts. Consistent with rational trunds. Corn wors FSEDs are primarily hecased in afficient suburban irrest relatively close. to urgert rans return and traditional emergency.

Proposerts of PSEDs explain that these facilities provide communities expented access to emergency coes. Opponents argue that shie to their statemakine Suithings and mindrelly to non-emergency building, it is possible for consumers to metale as PSED for as argent care center and wind us with an areopectedly



When are Coloradam using FSEDs? To inform the conversation, understand have Coloradien are using PSEOs, and explore potential cost implications, the Center for Improving Value in Health Care (CIVHC) analysed 2014 claims that from the Contracts All Paper Claims Chitabase (CO APCED)

Results indicate that of the top 10 reasons Coloradam sought immediate care in 2014, sever of the 10 reasons Act PGGO early were for rest-life themstering overse. This is to connect to fines out of 10 hospital-based ED while being necessary and, suggesting that perfects are using PEEDs in ways overs similar to singlest new nections than honettal-based EDs.

Top 18 Remove (not entired by frequency) Collinate Patients Seal Introduction Care Agrees Sentings (1714, Commenced Property CO. APRILL



Total Payments and Member Liability

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Compare Costs & Quality

Find a Facility

Methodology

Resources

know what to expect before you receive care

compare the costs & quality of healthcare procedures in Maine

find the cost of a procedure



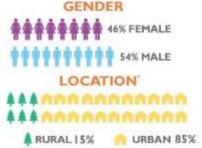
more information, better decisions,

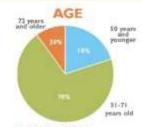
A Snapshot of Hepatitis C in Colorado



Hepatitis C is a liver infection caused by the Hippatitis C virus (HCV) and is transmitted through the blood. For some people. HCV is a short-term illness, but for 70% - 85% of people who become infected, it becomes a serious, long-term, chronic effection. The majority of infected persons might not be awars of their infection because they are not clinically ill.1 HCV is now the leading infectious disease killer in the US claiming approximately 20,000 American lives in 2014. III

Below is a snapshot of HCV prevalence in Colorado for 2013-2014 using claims data from the Colorado All Payer Claims Database (CO APCD). Data reflects Coloradars with claims filled through commercial payers (excluding self-insured lines of business), Medicaid, and Medicare Advantage. The largest age demographic diagnosed is the buby-boomer generation (\$1-71 years old) with the majority of individuals living in urban parts of the state. In spite of new easy to administer treatment options that essentially eliminate symptoms, many Coloradars are still not receiving any treatment for HCV.





BORN BETWEEN 1945-1961

BORNAFTER 1945

BORN BEFORE 1945

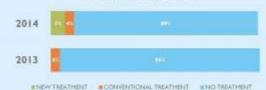
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TREATMENT

NEW At the and of 2013 and in early 2014, one drugs became available for the first time time. covered by devices again and symptoms of HCV and are the because to instance Second was the first own along to be the because and the problem and the second second

PRE & POST NEW TREATMENT TRENDS, 2013-2014



Although the release of Sovaldi and other curative HCV drugs in recent years have eliminated the complexity and length of treatment, the vast rejority of those diagnosed in Colorado remain untreated. In 2014, only 0.005% of individuals diaground with HCV moved from conventional treatment methods to new Understanding what is available and making treatment affordable and accessible is the first step toward reducing HCV in Colorado.

The picture of HCV in Colorado is complex in future publications, CIVHC will dig deeper into the affected patient populations, efficacy of treatments, and the costs associated with chronic infection.

Germany with Intuit from the Skagg: School of Pharmacy and Pharmacushial Science at the University of Coorado Assimus Medical Compus.

ness for Disease Cornell and Freezeway (CDC)(1816, April). Reports C - Liver Foundation (2014, April Retrieval Your Republic, Intelligence of the International April Retrieval Your Republic, and the Intelligence April Retrieval Your Republic, and the Intelligence of the Intelligence o Comers for Dissess Committee of Provincian (2016, Phys. CDC Receivors Reports C. 15th Plans Averages from Any Other Infloration Dissess, Revision) from Comers

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

Special Edition 1

The Utah Legislature gramed authority to the Usah Department of Health (UDOH) and the Usah Health Data Committee to collect data from healthcare powers with an entollment of 2,500 or more covered lives and create the Utah All Payer Claims Database (APCD): Utalik APCID collects medical, pharmacy, and dental claims data from both private and government. powers, including Medicard 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

- Utable APCID collects medical, pharmuce, and dental claims data from both private and government payers.
- Unth APCD's primary objective is in increase cont and quality transparency in our healthcare murkets.
- In 2014, the until healthcare payments reported to the APCD for patients under age 65 exceeded \$6.8 billion in Duck.
- Nearly half (47%) of the payments went to inputient and outputient facilities.
- Urah insurance carriers and their members paid, on average, about \$1,188 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 https://health.orde.gov/fida-

Claim Type by Site

impatient Pacifity

Outputient Facility

of Service

All

Total Payments and Member Liability

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Table 1. Payments of healthcare claims for persons upder age 68 in Claib. 2014.

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Total Paid

Amount

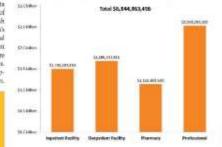
101.332.704 \$ 1.406.189.910

288,225,996 8 1,985,441,821

185,174,624 \$ 1,156,969,590

Total Paid Amount by Claim Type, Utah, 2014

Figure J. Tittal payments by claim type für pennim under age 65 m Otah, 5014.



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

Based on newly available data, we present the basic nummary infofrom an follows:

Table 1 presents information on the four primary types of her claims payments made in 2014 and reported to the APCD for under age 65. Total healthcare payments exceeded \$6.5 hillion wi hability maliting up 15% of total payments. Nearly half of the p ments went to impatient and outpatient facilities. In terms plus macy claims accounted for 47% of all claims.

Per-Person-Per-Year Healthcare Cost, Under Age 67 For the first time, the APCD enabled the UDOH to calculat Per-Year (PPPY) healthcare costs for the state of Uluh, Utub

6.8%

17.1%

10.5%

12.8%

150%

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

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CENTER FOR HEALTH INFORMATION AND ANALYSIS

PERFORMANCE OF THE MASSACHUSETTS HEALTH CARE SYSTEM

ANNUAL REPORT SEPTEMBER 2016



CENTER FOR HEALTH INFORMATION AND ANALYSIS

MASSHEALTH BASELINE STATISTICS

FFS & PCC PLAN (STYPRIA - STYPRIA)

MAY 2016



Cost Driver Spot Analysis: Payment Variation by Payer February 2016



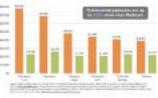
Some Coloradam Pay Significantly More than Medicare for the Same Service

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On croposition to health care speeding action papers from but to important regarding the drivers of occuspitation between the public and private sector The Colorado All Paper Claims Database (CO APCD) provides a compar opportunity to available paper system for specific are recent by paper type and identify crass of coor raisings parential.

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SPENDING AND USE AMONG MARYLAND'S PRIVATELY FULLY INSURED



Highlights: Spending and Use in Maryland

- · Liefreidual Maibet.
- Total associos (inamolo) as of December 31, 2014, in the individual market increased by about 20 percent.
- The member per month (EMPM) spending to the individual market for all services increased between 2013 and 2013 by short 31 peacess, mainly due to account one of services. Delignation per 1,000 members increased for all service entraperior, ranging from 10 peacent for professional services to 51 period for prescription drugs.
- In spite of increases in PMPM spending in the individual matter, this market continued to have the tower DMPM spinding across all monitors between the PMPM portion for invators instanced by 30 percent, while the out-of-packet SCOD PMPM for markets increased by 40 percent. This difference coulded in a discusse (ID percent) in the members' CCD state of total spending in 2016. Licewist, CCD spendings remained the highest in the multi-bland method congruent with the other conflicts cannot engage out with the other conflicts cannot engage out with the other conflicts.
- The median expenditure tisk nove increased from 6.00 to 6.20 between 2010 and 2016, indicating
 that new associates extending this surfact to 2010 were filledy delect, as expected, meeting none care,
 adds it increased 2010 by appending
- . Small Employer and Longs Employer Markets
- EMPM spending for all services combined remained contanged between 200 and 2014 the large employers, but declined for anothersplayers.
- PMPAC specifing the impatient services decreased in both the anull employer and the large employer merhods, but increased in the individual market.
- A Arrow Marketa
- That contains all service companies inserved in 2001, morphise impatient facility services? or which unit contri declinical across all mankets in 2001. This decrease in unit costs the trapsition facility arrvice (likely resoluted from the State's see "hospital global bedging program declared in 2015."
- Report for the common or the first described and beginning report of the first or more and will be from promoting.

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BACKGROUND

This Spetfight annuline health case spending and stillination patterns for Marshad anidotts inswed through the individual, modil employer, and long anglesyes markers. The analysis often on 2012 and 2014 data from Maryland's Medical Care Database (M.C.208, which contains bealth any delimental encounter data submitted.

Rehibited by the Maryland Health Core Germanian, Center for Assignia and Information Systems.

JUNE 2016

Potentially Preventable Emergency Room Visits

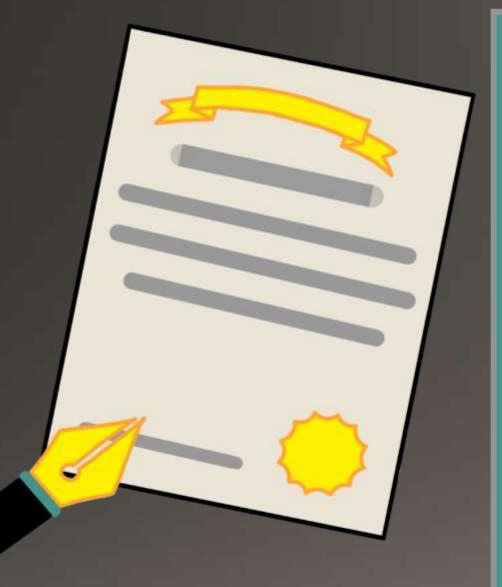
Introduction

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 healther 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 tess tikely 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 some \$50 million annually by preyending non-interpretary water to annually by preyending

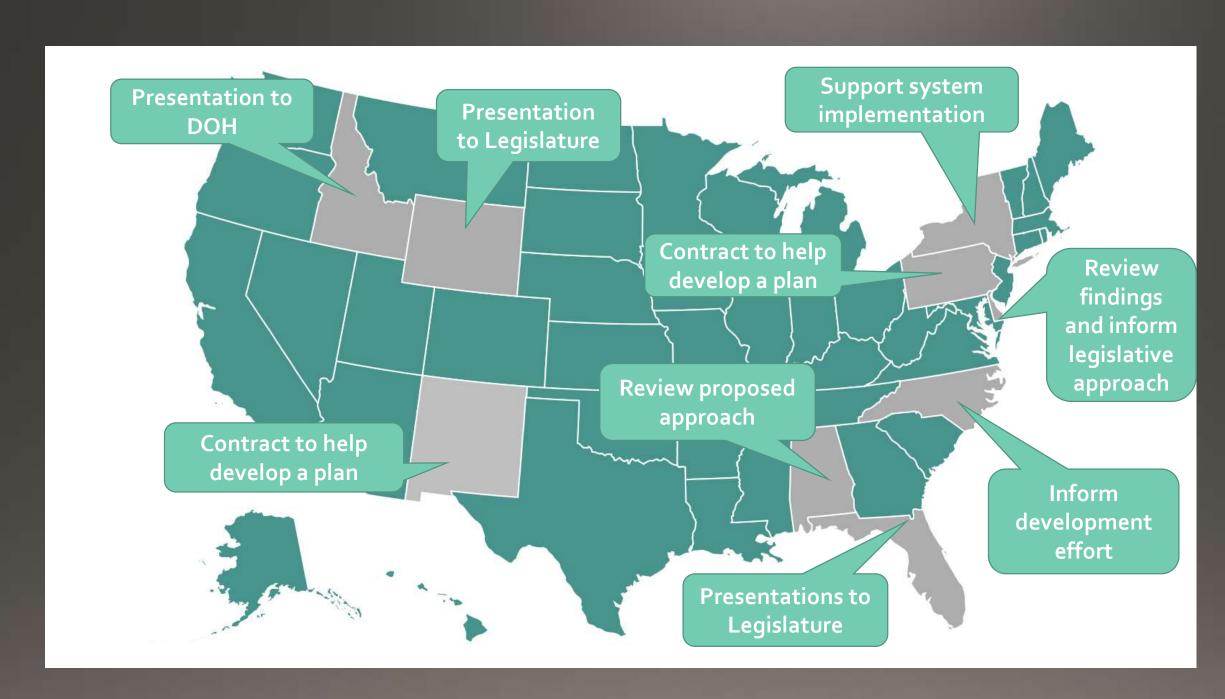
Next users one of the top resons for potentials reventable envergency room acts, and the most respensive etter access to primary care, and discusse management could als growent these wints. Apper respeatury infections, low book, and abdominal puri are common potentially preventable, reasons Rhisde standers go to the emergency learn.



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.



Activity at the National Level

Conversations at the National Level

Agency for Healthcare Research and Quality

National
Association of
Insurance
Commissioners

Network for Regional Health Improvement

Office of Personnel

Management

Centers for Medicaid and Medicare Services

National Academy of State Health Policy

> Office of the National Coordinator

Academy Health

National
Association of
Attorney Generals

National Center for Vital and Health Statistics

Association of
State and
Territorial Health
Offices

American Medical Association

Responding to key issues

SAMHSA Comments 42 CFR Part 2 – April 2016 MACRA
Comments
June 2016

SCOTUS *Gobeille vs. Liberty Mutual* ruling – March 2016

- Legal Workgroup with NASHP Finalized comments October 2016
- Common Data Layout Workgroup - Ongoing

DOL Annual Reporting and Disclosure Comments – October 2016

NCVHS APCD Hearing
June 2016

And follow up continues...

The Value of All-Payer Claims Databases for Employers

What are All-Payer Claims Databases (APCDs)?

APCDs are databases, typically oreated by a state mandate, that generally include data derived from medical claims, pharmacy claims, eligibility files, provider brightian and facility files, and dental claims. From private and public payers. Data are submitted directly from health insurers, third party administrations, and pharmacy benefit managers.

Why have APCDs been developed?

States have established state-sponsored APCD systems to fill or tical information gaps needed to make efflictive 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 at lication 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 welness and productivity in the workplace. In addition, one of the most important issues for employers is controlling health care costs. A recent article from Castigint Realth summarised the sour. This was:

"Rising healthcare costs place a huge strain on business. According to a new <u>Harris, Foll</u>, which consisted of more than 180 CPOs at large self-insured U.S. companies, 80% say they feel powerless when it comes to manual repther company's <u>healthcare</u> spending. Even more so, 90% agree that if their company's healthcare costs were <u>lower</u>, they could afford to invest more in their businesses."

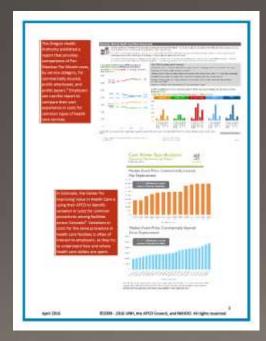
Health system performance improvement requires the availability of commenterable local data. Engloyers often seek more information to understand the quality of care their employees receive, how much variation there is in beath care costs, and what opportunities exist to improve the health and health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

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

State and Regional Benchmarking

Employers contribute significant amounts of money, often over \$10,000 per employers, in premiums for health insurance? 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 employers through their insurance companies, third party administrators, or other contractors, many businesses look any information to which they can compare, or benchmark, their own experience. Many state APCDs have state and regional reporting that provide analysis across payers, amorting comparisons that employers often lasts. Examples include:





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

The AR Payer Claims Debabase (APCD) Council has collected and compiled response to key questions posed to regulators in APCD states since the March I decision be the Supreme Count of the Linked States (SCOTUS) in Gobelile s. Liberty Marchi, related to key regulatory antonorement issues to be considered by states.

These responses are not record to provide legal advice and should not be relied upon an such lestead, this is a complication of opinions and regulatory interpretations that may help guide states as they assess the impact of the SCOTUS decision on APCD efform.

REGULATORY ENFORCEMENT ISSUES FOR APCD STATES

issue 1: Are state APCD statutes still enforceable?

Yes, APCD statutes are and present, for the most part, and acceptable. Health, resonance competities, providers, government health plane, and after APCD regulated emittes are still authorized to comply with APCD reporting violates. Unless sensitively directed by self-funders plan sponsors otherwise, Titoti-Farty Administrators (TPA) should also continue to comply with state APCD reporting regulatements.

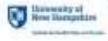
in Sobelie v. Liberty Mutuol, a Jeff funded plan sponsor (employer) dividinged the state of Vermoot's right to compel the enaphyer's TPA to submit stains data to the state's APCD regulated by the Green Mountain Care Soard, in its March 1, 2016 decision, SCITTUS confirmed that Vermont's statute, as applied to the self-funded employer's trigloyes flatterment income Society Act of 1974 (ERSA) plan, was preempted by ERSA.

Health insurerus companies and TRAs have questioned the breadth of the Gobellis discision. 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 source, suchabling fully insured plans; non-CRSA plans; and TRAs, as long as self-funded employer plans governed by IRISA have the opportunity to decide whether or not to submit their date.

Given the making, employers who offer self-funded ERSA plant may inform their TRA or the APCD that they decline to submit their data, and the state must comply with such a rehant.

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

Generally, governmental plans are energy from SNSA's provisions and are not impacted by the Godesile decision with regard to claims submissions. ERSA 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 subdiminion themos, or by any agreesy or









Calendar 2015 - 2016

Events, Conferences, And Where the Conversations are Happening

November 2015

State-University Partnership Learning Network Annual Meeting 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 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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