REPORT OF THE
JOINT COMMISSION ON HEALTH CARE

All-Payer Claims Databases

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

REPORT DOCUMENT NO. 107

COMMONWEALTH OF VIRGINIA
RICHMOND
2012

Code of Virginia § 30-168.

The Joint Commission on Health Care (the Commission) is established in the legislative branch of state government. The purpose of the Commission is to study, report and make recommendations on all areas of health care provision, regulation, insurance, liability, licensing, and delivery of services. In so doing, the Commission shall endeavor to ensure that the Commonwealth as provider, financier, and regulator adopts the most cost-effective and efficacious means of delivery of health care services so that the greatest number of Virginians receive quality health care. Further, the Commission shall encourage the development of uniform policies and services to ensure the availability of quality, affordable and accessible health services and provide a forum for continuing the review and study of programs and services.

The Commission may make recommendations and coordinate the proposals and recommendations of all commissions and agencies as to legislation affecting the provision and delivery of health care.

For the purposes of this chapter, "health care" shall include behavioral health care.

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Preface

A Joint Commission on Health Care report, *Catastrophic Health Insurance* – HD No. 3 (2011), included a policy option to review the idea of establishing an All-Payer Claims Database (APCD). APCDs, large-scale databases that manage systematically-collected health care claims data, can facilitate a better understanding of cost and utilization across institutions and populations.

The concepts involved in establishing an APCD were reviewed by the Joint Commission in 2011. The review revealed that APCD data analyses can provide useful information in such areas as health care costs, quality, and efficiency; geographic differences related to access and utilization; and overall system utilization.

Based on the study findings, JCHC members voted to introduce legislation to create an APCD specifying that the governance-structure should be housed within the nonprofit organization, Virginia Health Information; that data collection should adhere to national reporting standards for medical claims; and that health insurers be required to report health insurance claims data. House Bill 343 (Delegate O'Bannon) and Senate Bill 135 (Senator Puller) were introduced as companion bills during the 2012 General Assembly Session. During consideration by the General Assembly, the bills were amended to allow insurers to voluntarily report claims data. House Bill 343 and Senate Bill 135 were awaiting the Governor's signature when this report was submitted.

Joint Commission members and staff would like to thank the numerous individuals who assisted in this study, including representatives from: Aetna, Anthem, APCD Council, Castlight Health, Centers for Medicaid and Medicare Services, Medical Society of Virginia, Mercer, National Association of Health Data Organizations, National Conference of State Legislatures, National Governors Association, Onpoint Health Data, Sentara, Virginia Hospital & Healthcare Association, Virginia Association of Health Plans, Virginia Department of Health, Virginia Health Information, Virginia Health Reform Initiative, and WellPoint.

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All-Payer Claims Databases

A Joint Commission on Health Care report, *Catastrophic Health Insurance* – HD No. 3 (2011), included a policy option to review the idea of establishing an All-Payer Claims Database (APCD). This review was undertaken on behalf of the Joint Commission in 2011.

Background

Although spending on health care is a significant expense for individuals, families, private entities, and all levels of government, what makes up this spending is not well understood. As noted in an overview on All-Payer Claims Databases:

> "Gaps in…knowledge limit the ability to identify opportunities to address rising health care costs. In response to this lack of transparency in health care spending, states are actively seeking robust information about the costs and performance of their state's health care delivery system. One key source of information to support transparency and general knowledge of the health care marketplace is the development of All-Payer Claims Databases…."[1]

APCDs are large-scale databases that manage systematically-collected health care claims data from a variety of payer sources.[2] Examples of information that may be collected include: medical, pharmacy, and dental claims as well as eligibility and provider information from private (health insurance) and public (Medicare, Medicaid, Veterans Administration) payers. APCDs can facilitate a better understanding of cost and utilization across institutions and populations and support sub-state analysis. APCDs can be useful tools in tracking the performance of local delivery systems and in helping communities decide where to focus their improvement efforts to improve care delivery and efficiency.

Findings

The enhanced availability and transparency of health care information collected within an APCD can benefit many different groups.[3] For consumers, additional cost and quality measures for medical procedures could be published allowing for better-informed decision-making. For policymakers and researchers, an APCD can provide a better understanding of health care system costs and quality by geographic area as well as the market impact of proposed Medicaid, health care and payment reform changes. Employers can use APCD-generated information to benchmark health care cost, quality, preventive service measures, and high-cost cases across populations to improve health and wellness programs. Public health may be assisted through identifying and tracking the impact of public health strategies, enhancing public health surveillance and investigation, and improving understanding about diseases across settings and across payers.

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[1] Patrick Miller, Denise Love, Emily Sullivan, Jo Porter and Amy Costello, *All-Payer Claims Databases: An Overview for Policymakers*, Academy Health & State Coverage Initiatives, May 2010.
[2] Data elements typically collected for inclusion within APCDs include: encrypted SSN or member identification number; type of product (HMO, POS, Indemnity, etc.); type of contract (single person, family, etc.); patient demographics (DOB, gender, zip); diagnosis, procedure, and NDC codes; and information on service provider, prescribing physician, plan payments, member payment responsibility, type and date of bill paid, facility type, revenue codes, and service dates. *(Source: Id.)*
[3] *Id.*

Other States Have Implemented APCDs. Twelve states currently have an APCD and two states are in the process of implementing such databases.[4] As shown in Figure 1, the state databases focus on different aspects of the health care system and consequently gather and analyze different types of health care related information including cost, quality, efficiency, geographic differences in access and utilization, episodes of care, and overall system utilization.

Figure 1
APCD Focus by State[5]

	Cost	Quality	Efficiency	Geographic Differences	Episodes of Care	System Utilization
Kansas	■	■	■	■	■	■
Maine	■	■		■	■	■
Maryland	■		■	■		
Massachusetts	■					■
Minnesota	■	■		■	■	■
New Hampshire	■	■	■	■	■	■
Oregon	■					
Tennessee	■	■		■	■	■
Utah	■	■	■	■	■	■
Vermont	■	■		■	■	
Washington	■	■		■	■	■
Wisconsin	■	■	■		■	■

Some of the specific ways that APCD-supported analyses have been used include:[6]

- Helping employers understand variations in the cost and utilization of services by geographic area and in different provider settings (ME, NH).
- Exploring value (cost and quality) for services provided (NH).
- Informing design and evaluation plans for payment reform models (NH, VT).
- Evaluating the effect of health reforms on the cost, quality, and access to care in a state (MD, VT).
- Comparing utilization patterns across payers to inform state purchasing decisions for Medicaid (NH) and identifying successful cost containment strategies (NH, VT).

[4] The states with an APCD are listed in Table 1. Colorado and Rhode Island are in the process of implementation.
[5] JCHC staff correspondence with APCD Council representatives and Tennessee APCD website at http://www.tn.gov/finance/healthplanning/dataWarehouse.shtml.
[6] *See* note 1.

Health Care Data Collection in Virginia. The Commonwealth has supported transparency in health care information for decades. The Health Care Data Reporting Act (*Code of Virginia,* Title 32.1, Chapter 7.2), enacted in 1996, directed "the Commissioner of Health to contract with a nonprofit…health data organization to develop and implement health data projects that provide useful information to consumers and purchasers of health care, to providers including health plans, to hospitals and to nursing facilities and physicians."[7] The work of that nonprofit health data organization, Virginia Health Information (VHI), has expanded and includes the collection of some in-patient hospital and outpatient surgery information. However, there are significant limitations in the information that is collected. Additional information is essential in order to understand cost and utilization across institutions and populations and to have the ability to conduct comprehensive sub-state health care analyses.

Establishing a Virginia APCD. Joint Commission on Health Care (JCHC) staff provided a general overview regarding APCDs to the Joint Commission on June 14, 2011 (Attachment 1). At that time, JCHC members approved a recommendation to have the Healthy Living/Health Services Subcommittee study the APCD concept further.

The Healthy Living/Health Services Subcommittee met on October 3rd and heard presentations by the Virginia Hospital and Health Care Association, Virginia Association of Health Plans, and Virginia Health Information. The Subcommittee also discussed various guiding principles for establishing an APCD. If Virginia were to pursue creating an APCD, some of the important decisions which would need to be made include: governance structure, voluntary or mandatory submission of data, the payers that would be required to submit data, rules for release and for public dissemination of data, and funding sources to support the database. JCHC staff was directed to develop policy options regarding potential guiding principles. (The October 3rd meeting materials are included in Attachment 2.)

A staff presentation was made during the October 17th meeting of the Joint Commission. The presentation included a review of the types of health care questions an APCD could answer, other state's uses for their APCDs, important questions to answer when creating an APCD as well as potential policy options for JCHC-member consideration. (The October 17th meeting materials are included in Attachment 3.)

Policy Options and Public Comment

Nine written comments were received regarding five proposed policy options. Comments were submitted on behalf of the following organizations:

- Donald Gehring for Anthem
- Chalmers M. Nunn, Jr., M.D. for Centra
- Jodi Fuller for MeadWestvaco
- Nicole Riley for National Federation of Independent Business – Virginia (NFIB-VA)
- David R. Maizel, M.D. for Sentara
- Doug Gray for Virginia Association of Health Plans (VAHP)
- Eileen E. Ciccotelli, MPM for Virginia Business Coalition on Health (VBCH)

[7] Virginia Health Information's *2011 Annual Report and Strategic Plan Update*, p. 2.

- Christopher S. Bailey for Virginia Hospital and Healthcare Association (VHHA)
- Jim Cronin for UnitedHealthcare

Option 1: Take no action.

In Support: VAHP

Option 2: Introduce legislation and accompanying budget amendment *(amount is dependent on decisions made related to the APCD design and funding structure)* to amend Chapter 7.2 of Title 32.1 of the *Code of Virginia* to expand health data collected in order to develop an All-Payer Claims Database.

In Support: Centra, NFIB-VA, and VBCH
In Opposition: Anthem

Option 3: By letter of the JCHC Chairman, indicate support for the creation of a Virginia All-Payer Claims Database. The letter would be sent to the Senate Committee on Commerce and Labor; House Committee on Commerce and Labor; Senate Committee on Education and Health; and House Committee on Health, Welfare and Institutions.

(No comments in support or opposition)

Option 4: Include in the legislation or a Chairman's letter (if Option 2 or 3 is approved), specific attributes for the All-Payer Claims Database.

A. Governance structure is housed at:
  1. Virginia Health Information (VHI)
     In Support: Sentara, MeadWestvaco, and VHHA
  2. Another public or private entity other than VHI.
     (No comments in support or opposition)

B. Types of data collected
  1. Adhere to national reporting standards for medical claims (e.g. Accredited Standard Committee X12 standards when finalized)
     In Support: VAHP[8] and VBCH
  2. APCD will determine the required data elements
     (No comments in support or opposition)

C. Data collection from health insurers
  1. Mandated collection
     In Support: Centra, VBCH, and VHHA
     In Opposition: UnitedHealthcare
  2. Voluntary submission
     In Opposition: UnitedHealthcare

[8] VAHP supports this option only if an APCD is developed.

Option 5: Include in the 2012 work plan for JCHC's Healthy Living/Health Services Subcommittee, continued study of an All-Payer Claims Database for Virginia.

Summary of Public Comments Based on Position Taken

Supports taking no action:
Virginia Association of Health Plans

Supports APCD legislation:
National Federation of Independent Business – Virginia

Supports developing an APCD administered by VHI:
MeadWestvaco
Sentara
Virginia Hospital and Healthcare Association

Supports APCD legislation that requires insurers to report claims information:
Centra

Supports APCD legislation adhering to national data standards that requires reporting of claims information:
Virginia Business Coalition on Health

Opposes APCD legislation at this time and supports further study:
Anthem

Opposes an APCD at this time and recommends Virginia define data infrastructure goals and priorities in the near and long term, and construct a system to that end:
UnitedHealthcare

Subsequent Actions by the Joint Commission on Health Care. During the Joint Commission's 2011 Decision Matrix meeting, JCHC members voted to proceed with Policy Options 2, 4A, 4B, and 4C. Specifically these options involved introducing legislation and accompanying budget amendment to expand the health data collected in order to create an All-Payers Claim Database. The approved options specify that the governance-structure should be housed within the nonprofit organization, Virginia Health Information; that data collection should adhere to national reporting standards for medical claims; and that reporting of health insurance claims data should be made on a mandatory rather than voluntary basis.

House Bill 343 (Delegate O'Bannon) and Senate Bill 135 (Senator Puller) were introduced as companion bills during the 2012 General Assembly Session. During consideration by the General Assembly, the bills were amended to allow insurers to voluntarily report claims data. House Bill 343 and Senate Bill 135 were awaiting the Governor's signature when this report was submitted.

JCHC Staff for this Report
Stephen W. Bowman
Senior Staff Attorney/Methodologist

Attachments

June 14, 2011
JCHC Meeting

Staff Presentation:
All-Payer Claims Databases (APCDs)

October 3, 2011
Healthy Living/Health Services Subcommittee Meeting

Staff Presentation:
All-Payer Claims Databases

Presentation:
Carilion Clinic Perspectives on an APCD
Letter from Virginia Hospital & Healthcare Association
Letter from Sentara Medical Group

Presentation:
APCD Considerations – Virginia Association of Health Plans

Presentation:
APCDs – VHI Background and Key Considerations

October 17, 2011
JCHC Meeting

Staff Presentation:
All-Payer Claims Databases

All-Payer Claims Databases

JOINT COMMISSION ON HEALTH CARE

Stephen W. Bowman – Senior Policy Analyst/Methodologist

June 14, 2011

Agenda

- Background
- All-Payer Claims Database (APCD)
- APCD at VHI
- Potential Avenues for Further Study

Background: 2010 JCHC Approved Option

Staff review:

(i) other states' efforts to publicly disseminate expansive cost and quality information by specific facility and provider for selected medical procedures; and

(ii) legal, financial, data and other requirements for Virginia Health Information to provide similar specific cost and quality information through an All-Payer Claims Database in order to improve quality and health outcomes.

Background: Different Groups Can be Assisted by an APCD

The 2010 study option focused on APCDs to provide greater cost and quality transparency for consumers.

APCDs can also provide timely information about health care procedures, variation and costs for:

- Policymakers
- Researchers
- Employers
- Employees
- Providers
- Insurers
- Public Health
- Quality-efforts

APCD would allow Virginia to build on our current VHI system and enhance the knowledge of our health care system for better understanding, transparency of cost, and service performance.

– 2010 Virginia Health Reform Initiative report

Background Health Care Facts: State Costs, State Inflation, Sector Inflation and Region Quality

Fact 1: Virginia's 2004 per capita health care costs are lower than the U.S. ($4,822 vs. $5,283)

Fact 2: Virginia's annual health care inflation rate from 1991-2004 is higher than the U.S. average (5.6% vs. 5.5%)

Fact 3: Virginia health care sectors annual inflation from 1991-2004

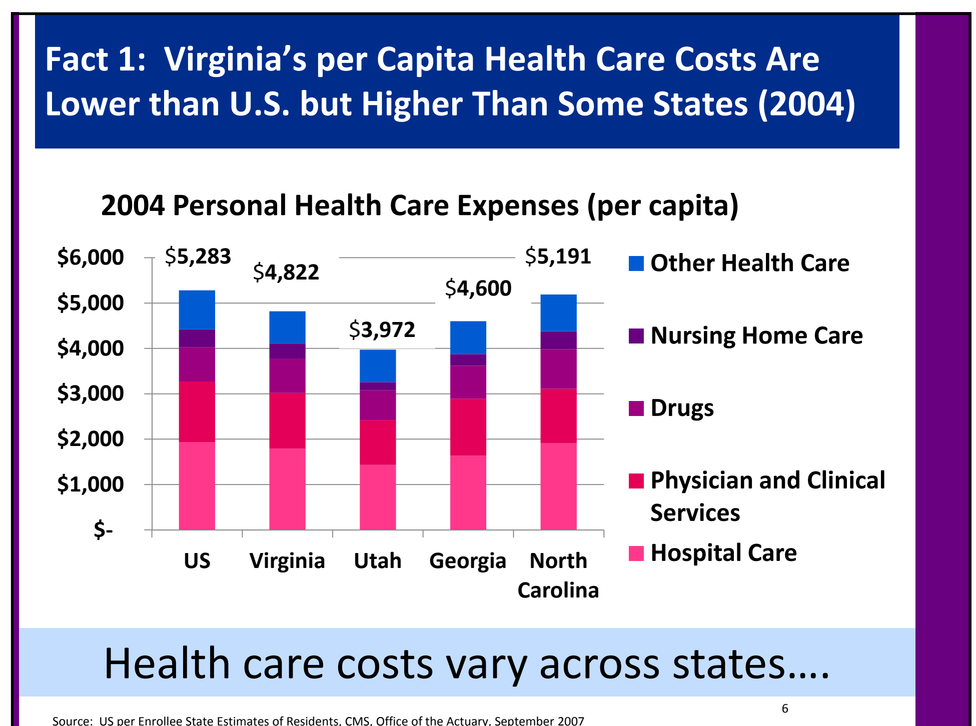
- Rx with medical non-durable expenses had the highest increases of 8.4%
- Hospital Care was lowest at 4.6%

Fact 4: Preventable hospital readmissions in Virginia differ by geography

Fact 5: More expensive health care does not yield higher quality

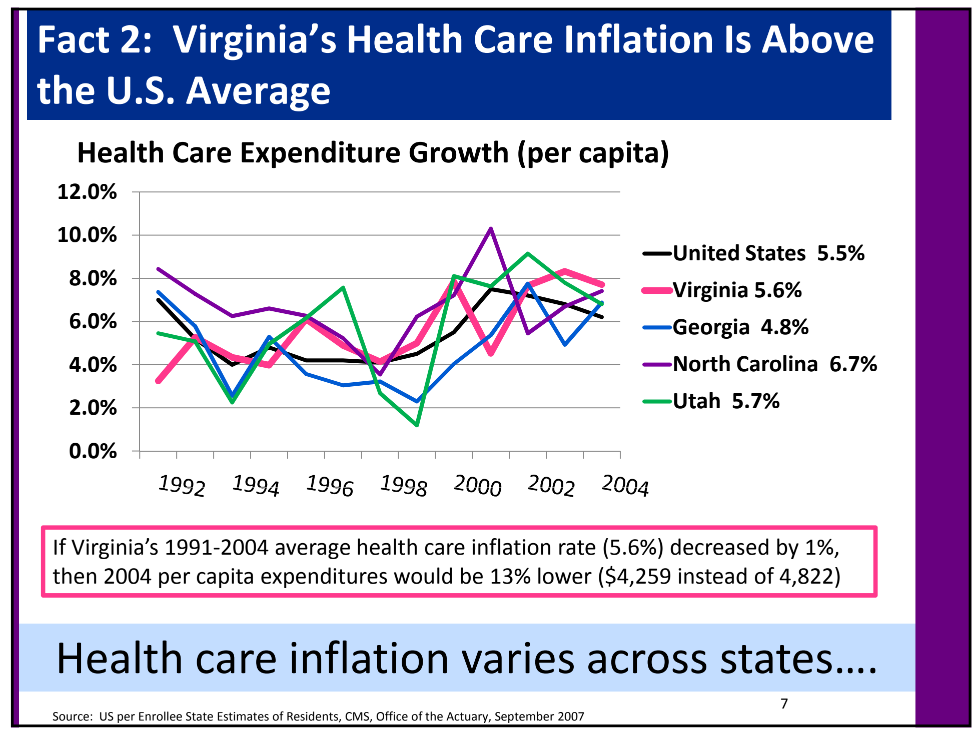
Fact 6: Significant variation exists for states' health care costs and inflation, health care sector costs and inflation as well as quality of care geographically

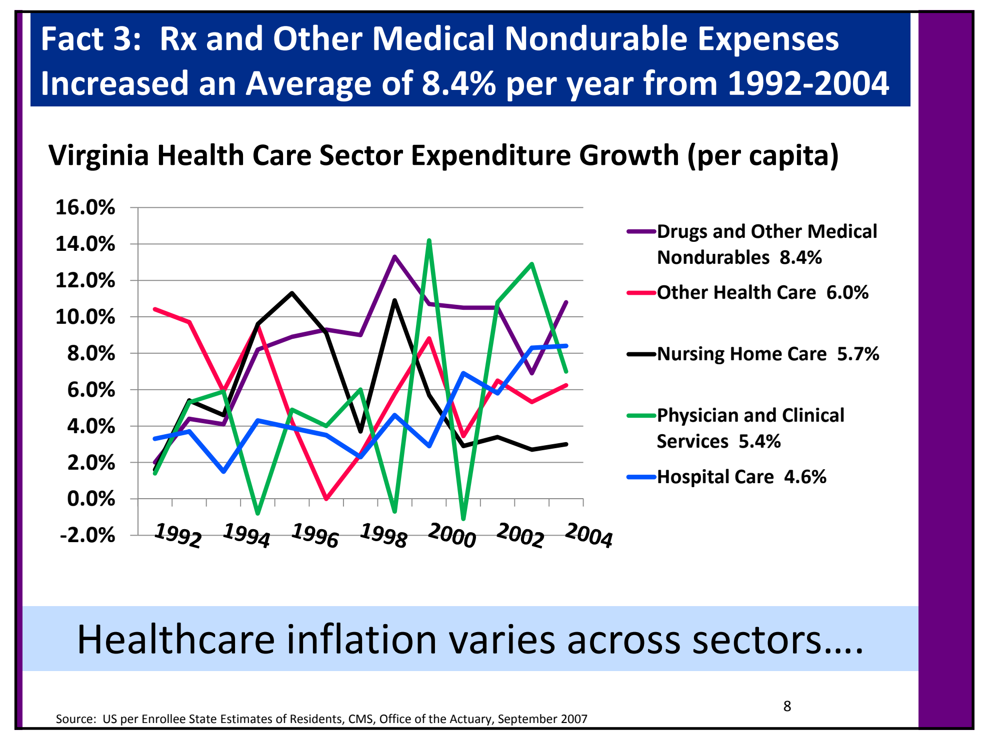
Fact 1: Virginia's per Capita Health Care Costs Are Lower than U.S. but Higher Than Some States (2004)



Health care costs vary across states….

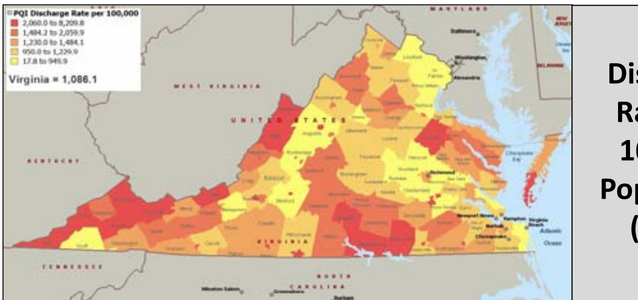
Source: US per Enrollee State Estimates of Residents, CMS, Office of the Actuary, September 2007


Fact 2: Virginia's Health Care Inflation Is Above the U.S. Average
Health Care Expenditure Growth (per capita)
12.0%
10.0%
8.0%
6.0%
4.0%
2.0%
0.0%
1992
1994
1996
1998
2000
2002
2004
United States 5.5%
Virginia 5.6%
Georgia 4.8%
North Carolina 6.7%
Utah 5.7%
If Virginia's 1991-2004 average health care inflation rate (5.6%) decreased by 1%, then 2004 per capita expenditures would be 13% lower ($4,259 instead of 4,822)
Health care inflation varies across states….
Source: US per Enrollee State Estimates of Residents, CMS, Office of the Actuary, September 2007
7


Fact 3: Rx and Other Medical Nondurable Expenses Increased an Average of 8.4% per year from 1992-2004
Virginia Health Care Sector Expenditure Growth (per capita)
16.0%
14.0%
12.0%
10.0%
8.0%
6.0%
4.0%
2.0%
0.0%
-2.0%
1992
1994
1996
1998
2000
2002
2004
Drugs and Other Medical Nondurables 8.4%
Other Health Care 6.0%
Nursing Home Care 5.7%
Physician and Clinical Services 5.4%
Hospital Care 4.6%
Healthcare inflation varies across sectors….
Source: US per Enrollee State Estimates of Residents, CMS, Office of the Actuary, September 2007
8

Fact 4: Preventable Hospital Readmissions in Virginia Differ by Geography

- 28% of localities are 1.5 times higher of State average (37 of 134)
- 18% are of localities are ½ or lower of State average (24 of 134)



PQI Discharge Rate per 100,000 Population (2009)

Prevention Quality Indicators (PQIs) can identify conditions for which good outpatient care can potentially prevent the need for hospitalization or for which early intervention can prevent complications or more severe disease.

Healthcare quality varies across Virginia….

Sources: Atlas of Community Health Map Book, March 2011, produced by Community Health Solutions at *vitality.communityhealthinfo.com, VHI website and JCHC staff analysis..*

Fact 5: More Expensive Health Care Does Not Yield Higher Quality

"The evidence does not indicate that higher Medicare spending is associated with better care for Medicare beneficiaries"
- Congressional Budget Office (CBO)

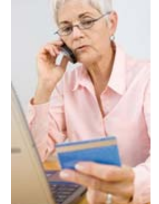
A 2008 CBO report on Medicare spending noted the following possible reasons for geographic variation in spending:

1. Differences among regions in the prices of medical services and in the population's health status
   - These factors most likely explain less than half of total variation, and possibly much less
2. Demographic factors and patients' treatment preferences
   - Contribute only a small amount to geographic variation
3. Much or most of the variation cannot be explained by prices, health status, demographics, or treatment preferences

Is the right care being provided?

Source: Geographic Variation in Health Care Spending, February 2008, Congressional Budget Office at http://www.cbo.gov/ftpdocs/89xx/doc8972/MainText.3.1.shtml

Consumers Are Expected to Be More Responsible for Health Care Expenses



Health Care Payment Trends

- ➢Consumers will "take on more of the risk associated with health care …."
- ➢"With persistent medical inflation, employers continue to promote greater employee cost sharing to reduce their health care spending."
- ➢"Individuals play a major role in the flow of health care funds. And [PPACA] will only increase the role of individuals."

Consumers are more financially involved in their care…

Source: McKinsey and Co., Then Next Wave of Change for U.S. Health Care Payment, McKinsey Quarterly, May 2010.

More Public Health Care Cost and Quality Data Could Facilitate Better Decisions

VHI Collects Information for Certain Health Care Services

Available Data

- Hospital in-patient
- Limited Outpatient surgery

Not Available Data

- Rx data
- Outpatient visits
- Other Outpatient procedures /tests
- Labs
- Dental
- Medical equipment

VHI cannot currently analyze across the care continuum and episodes of illness

VA Health Insurance Coverage (2009)
(% of population)

- Employer - 58%
- Individual - 4%
- Medicaid - 10%
- Medicare - 12%
- Other Public - 3%
- Uninsured - 13%

In Virginia, the only health care data across the care continuum that is publicly available is for Medicaid and Medicare beneficiaries (22% of the insured)

APCDs provide more health care information than is currently publicly available….

Source: Kaiser Family Foundation, StatehealthFacts, http://www.statehealthfacts.org/profileind.jsp?cmprgn=1&cat=3&rgn=48&ind=125&sub=39 & Patrick Miller, Denise Love, Emily Sullivan, Jo Porter and Amy Costello, All-Payer Claims Databases: An Overview for Policymakers, May 2010 & conversation with Michael Lundberg from VHI.

What Is an All-Payer Claims Database (APCD)?

Databases that typically include data derived from medical, eligibility, provider, pharmacy, and/or dental claims from private and public payers:

- Insurance carriers
  - Medical, dental, third party administrators (TPAs), pharmacy benefit managers (PBMs)
- Public payers
  - Medicaid, Medicare, Veterans Administration

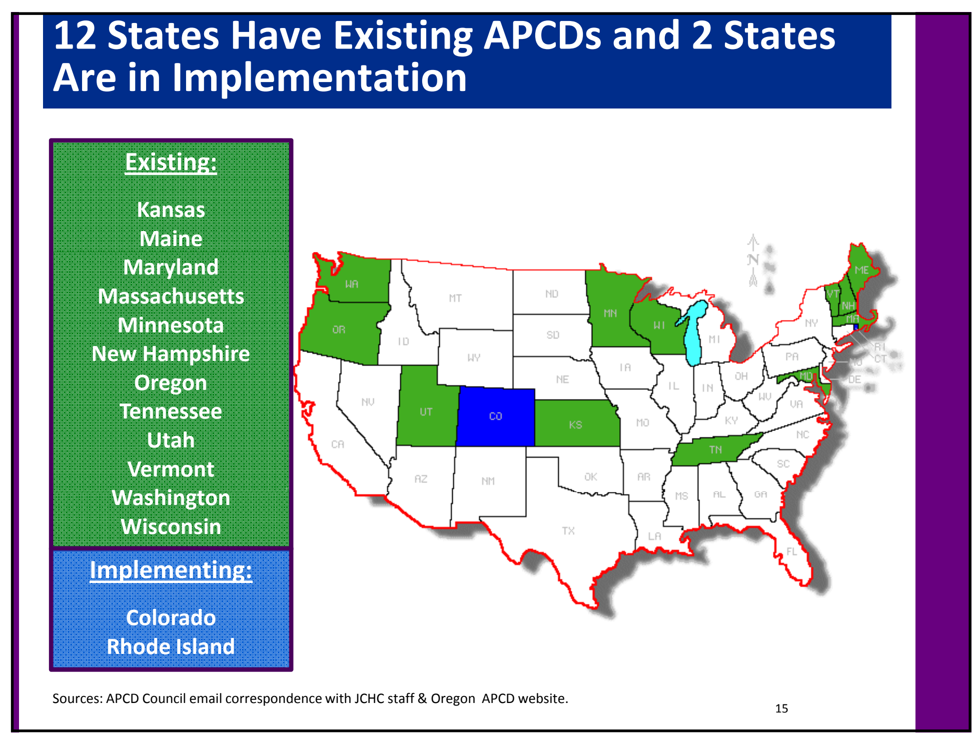
APCDs can allow for a broad understanding of cost and utilization across institutions and populations

Source: Slide from NAHDO Annual Conference, October 2009
Patrick Miller, MPH Research Associate Professor, University of New Hampshire (revised by JCHC staff).

APCDs Can Answer Many Health Care Questions

- Which hospitals, surgical centers or doctors have the highest ratings for certain medical procedures?
- Which hospitals, surgical centers or doctors have the lowest prices by procedure, or treatment? What do health insurance companies pay for these services?
- In what geographic areas is public health improving?
- If emergency room usage in Medicaid is higher than the commercial population, what are the possible reasons?
- How far do people travel for services and for what type of services?
- Are established clinical guideline measurements related to quality, safety, and continuity of care being met?
- What are the key public health issues by city and county?

Sources: Slide content from Alan Prysunka presentation to Virginia Health Reform Initiative Technology Task Force November 16, 2010 & Patrick Miller, Denise Love, Emily Sullivan, Jo Porter and Amy Costello, All-Payer Claims Databases: An Overview for Policymakers, May 2010.



APCD Primary Focus Varies Among States

	Cost	Quality	Efficiency	Geographic Differences	Episodes of Care	System Utilization
Kansas	■	■	■	■	■	■
Maine	■	■		■	■	■
Maryland	■		■	■		
Massachusetts	■					■
Minnesota	■	■		■	■	■
New Hampshire	■	■	■	■	■	■
Oregon	■					
Tennessee	■	■		■	■	■
Utah	■	■	■	■	■	■
Vermont	■	■		■	■	
Washington	■	■		■	■	■
Wisconsin	■	■	■		■	■

Other uses include: cost and quality benchmarking for Medicaid payment rates, measuring competition within the commercial health market, and potential risk adjustments.

Sources: APCD Council correspondence with JCHC staff & Tennessee APCD website.

Specific State Uses for APCDs

- Help employers understand variations in the cost and utilization of services by geographic area and in different provider settings (ME, NH)
- Explore value (cost and quality) for services provided (NH)
- Inform design and evaluation plans for payment reform models (NH, VT)
- Evaluate the effect of health reforms on the cost, quality, and access to care in a state (MD, VT)
- Compare utilization patterns across payers to inform state purchasing decisions for Medicaid (NH) and identify successful cost containment strategies (NH, VT)

Source: Patrick Miller, Denise Love, Emily Sullivan, Jo Porter and Amy Costello, All-Payer Claims Databases: An Overview for Policymakers, May 2010.

States Will Have a More Significant Role in the Health Care Market

PPACA increases the number of health care market participants overseen by states

- Insured State employees *(currently)*
- Health Benefits Exchange participants in 2014 *(if state-operated)*
- U.S. Medicaid program
  - Enrollees
    - 60 million *(currently)*
    - Additional 16 million in 2014
  - Percentage of state budgets
    - 22% average
    - 25-30% average in 2014

Virginia Medicaid Facts

FY 2001 to FY 2010
- Budget increased 122% (5x inflation rate)

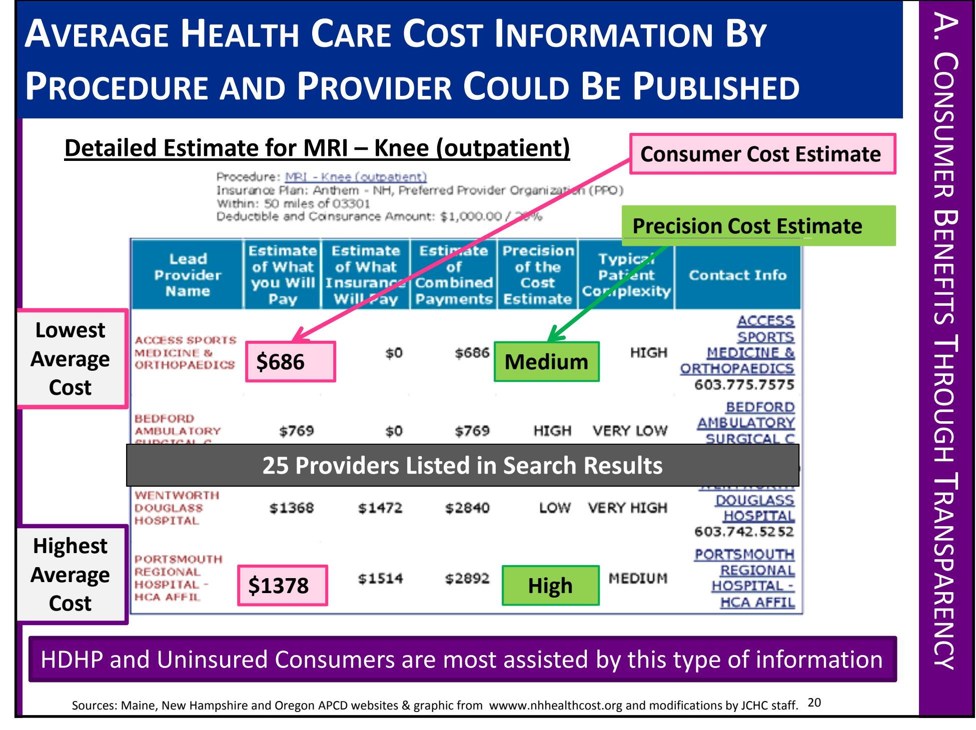
Enrollment
- 764,000 in 2010
- Additional 271,000 – 425,000 in 2014

% of State budget
- 20.7% state-only portion
- 18.8% of total

Sources: , Brad Finnegan, National Governors Association, APCD: A View from NGA, presentation October 15, 2010, Report of the Virginia Health Reform Initiative Advisory Council, December 20, 2010. & JLARC, Review of State Spending: 2010 Update

APCDs CAN BENEFIT DIFFERENT GROUPS AND AREAS

A. Consumers
B. Policymakers
C. Researchers
D. Employers
E. Employees
F. Providers
G. Insurers
H. Public Health
I. Quality-efforts



Sources: Maine, New Hampshire and Oregon APCD websites & graphic from www.nhhealthcost.org and modifications by JCHC staff.

APCDs Provide a Better Tool to Develop Policies and Assess a Proposed Policy's Impact

Policymakers

- Provide a better understanding of current health care system and its costs and quality by geographic area
- Assess market impact of proposed health policy changes
  - Medicaid
  - Health care and payment reforms
  - Mandated Health Insurance Benefits Commission

Researchers

- Investigate specific Virginia health care cost data to identify trends in costs, quality, and usage

Source: Patrick Miller, Denise Love, Emily Sullivan, Jo Porter and Amy Costello, All-Payer Claims Databases: An Overview for Policymakers, May 2010.

APCDs Provides Information to Structure Better Medicaid Policies

- Benchmarking payments compared to commercial payers across primary care, inpatient, and outpatient services
- Better understand patterns, cost, and quality by comparing to commercial market

Payment Rate Benchmarking in New Hampshire

Procedure Code	Average Payment Including Patient Share, 2006			
	Health Plan 1	Health Plan 2	Health Plan 3	NH Medicaid
99203 Office/Outpatient Visit New Patient, 30 minutes	$124	$115	$130	$42
99212 Office/Outpatient Visit Established Patient, 10 minutes	$51	$48	$52	$30
99391 Preventive Medicine Visit Established Patient Age <1	$111	$102	$107	$61
90806 Individual Psychotherapy in Office/ Outpatient, 45–50 minutes	$72	$71	$71	$61

Source: NH Department of Health and Human Services payment rate benchmarking study.

Source: APCD Council, All-Payer Claims Databases in Public Health and Medicaid: A Fact Sheet

APCDs Can Help Employees to Make Better Care Decisions

APCD is a tool that can assist employers in facilitating the lowest cost, best quality care at the right time for employees

- Employers are shifting more health care costs to employees
- Most helpful for employers that offer high-deductible health plans or tiered plans

APCD benchmarking of cost, quality, preventive service measures, and high-cost cases across populations to improve health and wellness programs

Educate employees about hospital costs and quality

Source: Patrick Miller, Denise Love, Emily Sullivan, Jo Porter and Amy Costello, All-Payer Claims Databases: An Overview for Policymakers,, May 2010.

D & E. EMPLOYEE AND EMPLOYER BENEFITS

APCDs Promote Better Information to Understand and Manage Insured Populations

Providers

- Hospitals need better information to understand care offered in outpatient settings and costs in movement towards accountable care organizations (ACOs)
- Identify practice inefficiencies and adjust accordingly
- Insurer negotiation

Insurers

- Better prepare to manage new insured populations
- Cost, quality, and utilization benchmarking
- Provider negotiation

Source: Patrick Miller, Denise Love, Emily Sullivan, Jo Porter and Amy Costello, All-Payer Claims Databases: An Overview for Policymakers,, May 2010.

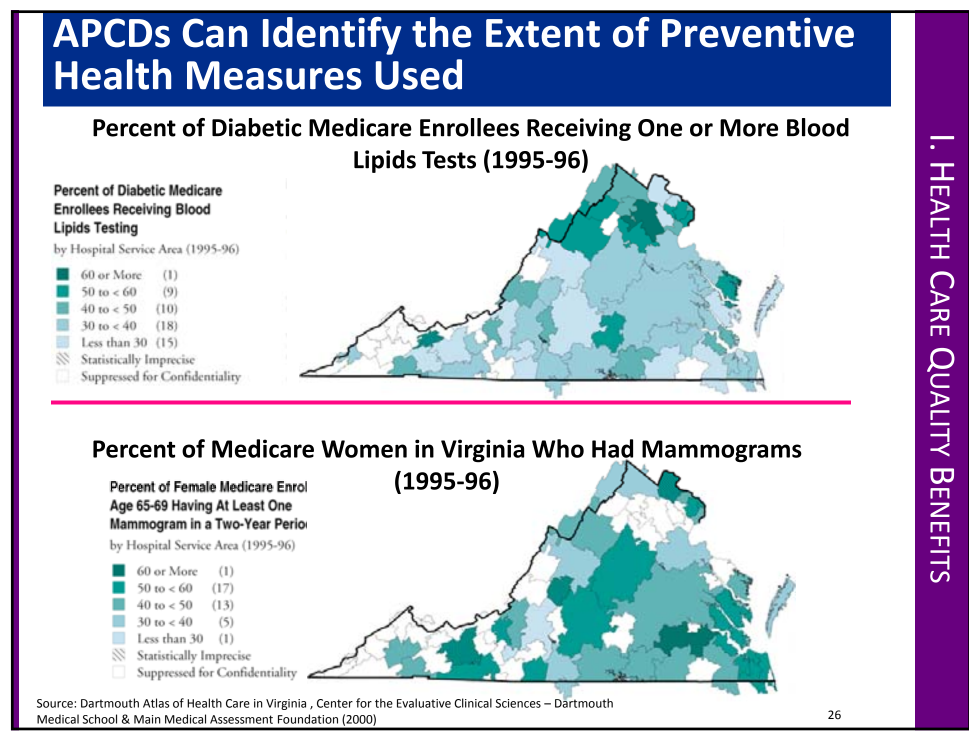
F & G. PROVIDER AND INSURER BENEFITS

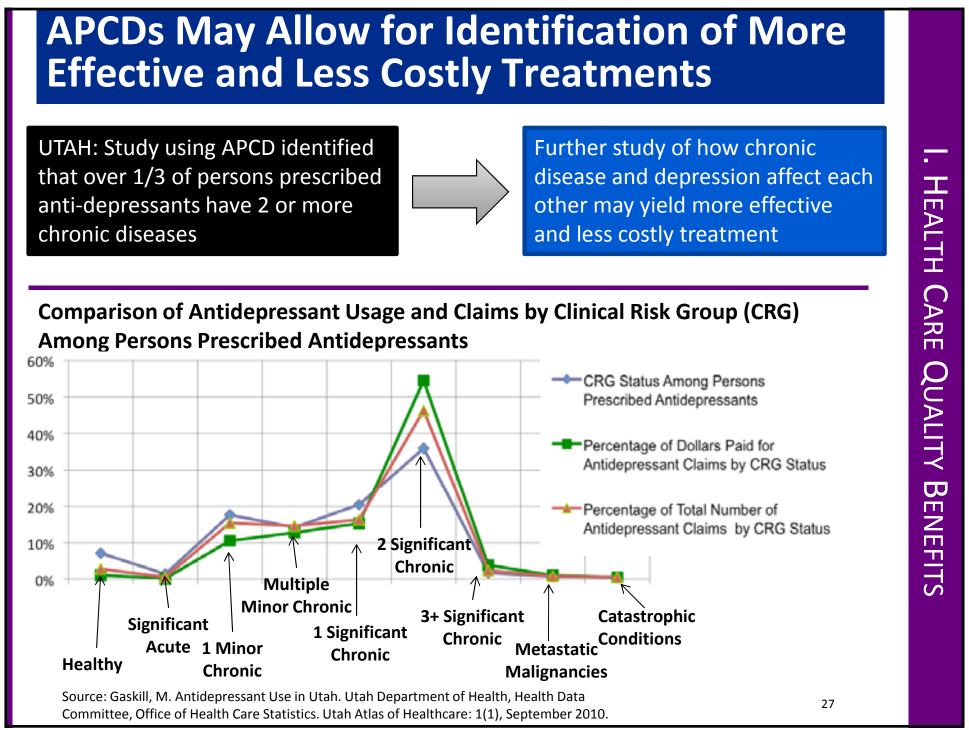
Better Understanding, Evaluation, and Targeting of Public Health Efforts

- Identify and track success of strategies to provide consistent high quality preventive health and health care
  - To better understand cause for high re-admission rates, investigate the likelihood of outpatient check-ups between admissions
  - Understand what is leading to the current improvement in cardiac care for African-American women in Virginia
    - VDH's only Virginia data to investigate heart attacks are from inpatient records and catheterization labs
- Use for public health surveillance and investigation
  - VDHs current Lyme Disease investigation is limited because incidence data only comes from hospital admissions and lab tests and ***not*** from outpatient settings where diagnoses occur without a lab test
- Improve understanding about diseases across settings and across payers
  - Outpatient care treats many injuries, diseases, and conditions but information is not consistently captured
- Identify lifetime health care costs and value of interventions by linking to vital records

Source: APCD Council, All-Payer Claims Databases in Public Health and Medicaid: A Fact Sheet & JCHC staff discussion with Virginia's Health Commissioner, Karen Remley.

H. PUBLIC HEALTH BENEFITS





Is VHI an Appropriate Location for an APCD?

VHI Benefits

- Currently manages some typical APCD information for inpatient and outpatient surgery services
- Track record of success managing, analyzing, and publishing health care cost and quality information
  - VDH contracts with VHI to provide health care provider and insurer cost and quality data
- Existing data and confidentiality policies
- Existing data management processes
- Existing relationships with stakeholders
- Governance structure contains stakeholders

VHI publicly provides health care cost information from insurers

- Pursuant to HB 603 (2008)

Common APCD Concerns Raised in States

- Which entities would be required to submit data
  - Cost of compliance for entities providing information
- Consumer data privacy and security
- Assuring that any specific provider-level price and quality data reported is accurate
  - Accounting for patient case complexity
- Providing provider payment rates publicly could increase health care costs

Source: NSCL Briefs for State Legislators, Collecting Health Data: All-Payer Claims Databases, May 2010.

FURTHER STUDY AVENUES

Potential Further Study Avenues

Avenue 1: No further action by JCHC staff

Avenue 2: Create a special Subcommittee of JCHC members to review APCDs further and possibly recommend specific APCD-related options during the JCHC October 17, 2011 meeting. *(Stakeholders would be invited to present and participate during the sub-committee meetings.)*

Specific Issues That Would Need to Be Worked Through for a Virginia APCD

- APCD Governance
- APCD Focus
- Data collection
  - Mandated submission?
  - Which payers submit data?
  - Does data include patient identifier data?
- Data release rules
- Public dissemination of data
- Funding
  - VHI-provided estimates to house APCD and associated analytics based on national data
    - $1 million startup
    - $750K - $1 million in annual costs

Many APCD permutations are possible

Sources: Denise Love, William Custer and Patrick Miller, All-Payer Claims Databases: State Initiatives to Improve Health Care Transparency, September 2010 & discussion with Michael Lundberg of VHI.

A: VHI information

Appendix A: VHI Board of Directors Nominating Organizations

Business
Virginia Chamber of Commerce
Virginia Business Council
Virginia Manufacturers Association

Hospital
Virginia Hospital and Healthcare Association

Insurance
Anthem
Virginia Association of Health Plans

Nursing Facility
Virginia Association of Nonprofit Homes for the Aging
Virginia Health Care Association

Physician
Medical Society of Virginia
Old Dominion Medical Society

State
Joint Commission on Health Care
Virginia Department of Health

Source: http://www.vhi.org/about_stakeholders.asp

VHI Current Databases

- Inpatient Hospital Discharges
- Financial and Operational Data for Hospitals and Nursing Facilities (EPICS)
- Hospital obstetric programs
- Outpatient Surgery (7 specific procedure groups)
- HMO Rankings based on HEDIS CAHPS information
- Average Health Plan Allowed Amounts for 31 Commonly Performed Services
- CON Survey data; ambulatory surgical centers, hospitals, nursing facilities, MRI centers

VHI Data Gaps

- Outpatient visits – including emergency care, doctor's visits
- Outpatient procedures – imaging, diagnostics, less than 24 hour admissions, chemotherapy, procedures,
- Ancillary services, pharmacy, lab, physical therapy, dental
- Any other covered costs

Source: Virginia Health Reform Initiative , Health IT and Transformed Health Care presentation, August 21, 2010

VHI Already Collects and Manages Some Typical APCD Information

Types of APCD Data Collected

Typical APCD Information

Patient/Clinical Information

- Patient identifier(encrypted)
- Type of product (HMO, PPO, FFS, etc.)
- Type of contract (single person, family)
- Patient demographics (DOB, gender, residence, relationship to subscriber)
- Diagnosis codes (including E-codes)
- Procedure codes (ICD, CPT, HCPCs)
- NDC code /generic indicator

Financial

- Revenue codes
- Service dates
- Service provider (name, tax ID, payer ID, specialty codes, location)
- Prescribing physician
- Plan payments
- Member payment responsibility (co-pay, co-insurance, deductible)
- Date paid
- Type of bill
- Facility type

Categories Highlighted in Red are currently collected by VHI

Source: Patrick Miller, Denise Love, Emily Sullivan, Jo Porter and Amy Costello, All-Payer Claims Databases: An Overview for Policymakers,, May 2010 & email correspondence with Michael Lundburg, VHI.

All-Payer Claims Databases

Joint Commission on Health Care
Stephen W. Bowman
Senior Staff Attorney/Methodologist

October 3, 2011

Significant variation exists in health care costs, inflation, and quality by location

Fact 1: Virginia's 2004 per capita health care costs are lower than the U.S. ($4,822 vs. $5,283)

Fact 2: Virginia's annual health care inflation rate from 1991-2004 is higher than the U.S. average (5.6% vs. 5.5%)

Fact 3: Virginia health care sectors' annual inflation from 1991-2004

- Rx with medical non-durable expenses had the highest increases of 8.4%
- Hospital Care was lowest at 4.6%

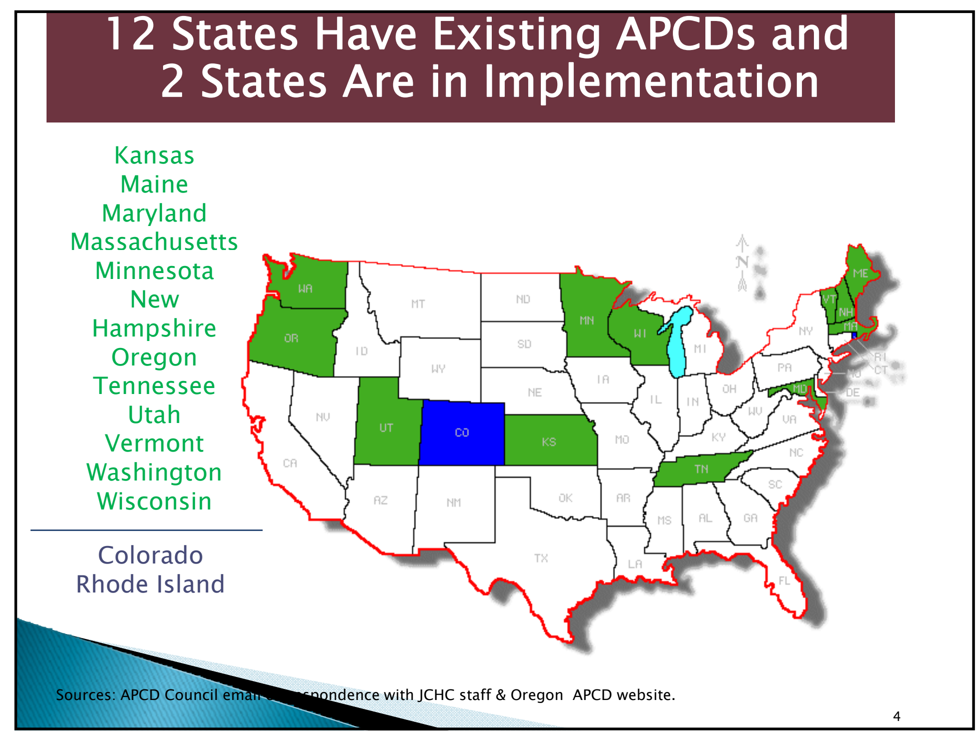
Fact 4: Preventable hospital readmissions in Virginia differ by geography

Fact 5: More expensive health care does not yield higher quality

What Is an All-Payer Claims Database?

- Databases that typically include data derived from medical, eligibility, provider, pharmacy, and/or dental claims from private and public payers:
  - Insurance carriers
    - Medical, dental, third party administrators (TPAs), pharmacy benefit managers (PBMs)
  - Public payers
    - Medicaid, Medicare, Veterans Administration
- APCDs can allow for a broad understanding of cost and utilization across institutions and populations

Source: Slide from NAHDO Annual Conference, October 2009
Patrick Miller, MPH Research Associate Professor, University of New Hampshire (revised by JCHC staff).



APCDs Can Answer Many Types of Health Care Questions

Cost

Which hospitals, surgical centers or doctors have the lowest prices by procedure, or treatment?

What do health insurance companies pay for health care services?

Access

How far do people travel for services and for what type of services?

Medicaid

Is emergency room usage in Medicaid higher than the commercial population? What are the possible reasons?

Quality

- Which hospitals, surgical centers or doctors have the highest ratings for certain medical procedures?
- Are established clinical guideline measurements related to quality, safety, and continuity of care being met?

Public Health

- What are the key public health issues by city and county?
- In what geographic areas is public health improving?

Sources: Slide content from Alan Prysunka presentation to Virginia Health Reform Initiative Technology Task Force November 16, 2010 & Patrick M... Denise Love, Emily Sullivan, Jo Porter and Amy Costello, All-Payer Claims Databases: An Overview for Policymake... 2010.

APCD Primary Focus Varies Among States

	Cost	Quality	Efficiency	Geographic Differences	Episodes of Care	System Utilization
Kansas	■	■	■	■	■	■
Maine	■	■		■	■	■
Maryland	■		■	■		
Massachusetts	■					■
Minnesota	■	■		■	■	■
New Hampshire	■	■	■	■	■	■
Oregon	■					
Tennessee	■	■		■	■	■
Utah	■	■	■	■	■	■
Vermont	■	■		■	■	
Washington	■	■		■	■	■
Wisconsin	■	■	■		■	■

Other uses include: cost and quality benchmarking for Medicaid payment rates, measuring competition within the commercial health market, and potential risk adjustments.

Sources: APCD Council correspondence ... CHC staff & Tennessee APCD website.

Specific State Uses for APCDs

- Help employers understand variations in the cost and utilization of services by geographic area and in different provider settings (ME, NH)
- Explore value (cost and quality) for services provided (NH)
- Inform design and evaluation plans for payment reform models (NH, VT)
- Evaluate the effect of health reforms on the cost, quality, and access to care in a state (MD, VT)
- Compare utilization patterns across payers to inform state purchasing decisions for Medicaid (NH) and identify successful cost containment strategies (NH, VT)

Source: Patrick Miller, Denise Lo[illegible] [illegible]mily Sullivan, Jo Porter and Amy Costello, All-Payer Claims Databases: An Overview for Policymake[illegible] [illegible] 2010.

Important APCD Elements

- APCD Governance
- APCD Focus
- Data collection
  - Mandated submission?
  - Which payers submit data?
  - Does data include patient identifier information?
- Data release rules
- Public dissemination of data
- Funding

Many APCD permutations are possible

Sources: Denise Love, William Custer and Patrick Miller, All-Payer Claims Databases: State Initiatives to Improve Health Care Transparency, September 2010 & discussion with Michael Lundberg of VHI.

Carilion Clinic

Perspectives on an All-Payer
Claims Database

Carilion Clinic the Employer

- 10,956 employees
- 600 physicians in 60 specialties
- 120 practice site covering 28 localities

Total revenues: $1.24 billion
Total community benefit: $154.9 million

Carilion Clinic the Provider

Approximately 1 million lives in our service area:

- Primary Service Area (PSA): 653,717
- Secondary Service Area: 334,379

- 768,576 primary care visits
- 48,541 admissions
- 180,881 ED visits

Carilion Clinic the Payer

- New partnership with Aetna
  - Lower costs of health benefits for our employees
  - Develop new insurance plans that reward better patient health outcomes while lowering costs.
- Medicare Advantage Plan started 2010
- Medicaid MCO beginning 1/1/12

What are we concerned about?

Our issues similar to other stakeholders'.

- Health care costs on unsustainable trajectory
- 20% of patients generate 80% of costs
- 20-30% of healthcare of no value
- 50% of patients do not get needed care
- Improving quality, reducing risk & eliminating waste are key to VALUE!

Obstacles to Improving Value

- FFS payment system incents overutilization
  - Tort system reinforces this as standard of care
- Lack of good health policy
  - Caring for the poor, uninsured & underinsured
  - Funding medical education
  - Smoking & other health risk
- Lack of data
  - Longitudinal
  - All payers
  - All services

What would we do with an APCD?
Employer

Our goal is to keep our employees healthy and productive.

1. Benchmark utilization of employees to identify opportunities as well as best practices
2. Identify at-risk employees for early intervention
3. Track impact of changes in plan design and care management
4. Compare performance of providers

What would we do with an APCD?
Provider

Our goal is to provide the best possible care.

1. Benchmark utilization of patients to identify opportunities as well as best practices
2. Identify care redundancies and eliminate them
3. Identify at-risk patients for early intervention
4. Use to facilitate collaboration with other providers, with employers and with payers
5. Gain better insight into health status and needs of the community

What would we do with an APCD?
Payer

Our goal is to ensure that our employees and communities have access to affordable coverage and optimal health.

1. Identify the needs of specific communities and tailor coverage for them.
2. Hold ourselves and other providers accountable for quality improvement
3. Eliminate coverage gaps and redundancies to ensure efficient health care delivery

Closing Thoughts

- Health Care costs are on an unsustainable trajectory
- Most health care costs relate to patients with one or more chronic diseases
- There is waste in the system yet many do not get needed care
- Wide variation in adherence to best practices
- We have sketchy/incomplete information about the full array of health care services used.

We can't improve what we can't measure.

An APCD is a ***tool*** *for improvement for all stakeholders.*

CARILION CLINIC

4200 INNSLAKE DRIVE, GLEN ALLEN, VIRGINIA 23060-6712
P.O. BOX 31394, RICHMOND, VIRGINIA 23294-1394
(804) 965-1227 FAX (804) 965-0475

September 30, 2011

The Honorable Benjamin L. Cline
Chairman
The Joint Commission on Health Care
P.O. Box 1322
Richmond, VA 23218

Dear Mr. Chairman:

The Joint Commission on Health Care (JCHC) is currently examining the benefits of creating an All-Payer Claims Database (APCD) in Virginia. APCDs exist in several states and their outcomes have been positive. By bringing together stakeholders to work through the issues at stake, Virginia can also create an effective APCD that provides a valuable resource for health care quality improvement and controlling costs.

During the June JCHC meeting, several issues were raised regarding the legislation and ultimate implementation of the database. We wish to offer these suggestions to consider during your process:

- The APCD should have a clear focus on improving health care quality and controlling costs. This focus should drive all data-collection and reporting efforts.

- VHI is an ideal location to house an APCD. In particular, its governing board is already comprised of key stakeholders: consumers, business, provider, payer, and Commonwealth. This board has significant experience dealing with the issues affecting the use and reporting of health care data. An APCD would be a natural extension of their current mission.

- VHI should be able to raise the capital necessary to create and maintain an APCD without any additional state appropriation. Other states have combined voluntary data subscriptions with federal, state and private grant funding in order to sustain their efforts.

- In order to ensure that a meaningful data set can be created, claim submission by all payers must be mandated by the General Assembly. Patients utilize health care in a variety of settings and pay for it in vastly different ways. Without the claims of all payers for all services, significant information gaps will emerge and render the data meaningless.

- How the data is used and reported is the most important question whose answer will likely change over time. The General Assembly should establish broad, but well-defined data use parameters that will create a framework within which the governing board of VHI can make the ultimate data-use decisions. This will allow the board flexibility in its decision-making while still providing adequate accountability to the General Assembly.

It is our desire to see the JCHC recommend the creation of an APCD to the General Assembly. Virginia's health care system has come as far as it can without accessible, broad-spectrum data. If we fail to create an APCD, it will send the message that we do not need to improve our quality or control our costs. Since this is clearly not the case, the General Assembly must create an APCD so that all stakeholders can begin to make more-informed decisions that improve quality and control cost.

Sincerely,

Christopher S. Bailey
Senior Vice President

xc: Members - Joint Commission on Health Care

Sentara Medical Group
Executive Office
835 Glenrock Road, Suite 200
Norfolk, Virginia 23502
Tel: (757) 252-3148
Fax: (757) 252-3146

drmaizel@sentara.com

David R. Maizel, M.D., ABFP, FAAFP
CVP & President

September 29, 2011

The Honorable Ben Cline
Chairman
The Joint Commission on Health Care
PO Box 1322
Richmond, VA 23218

Dear Mr. Chairman:

I write to you on behalf of Sentara Medical Group (SMG), a practice of more than 650 primary care and specialty physicians and advanced practice clinicians (nurse practitioners and physician assistants) serving Hampton Roads as well as Harrisonburg, Charlottesville and the exurbs of Northern Virginia. I wish to voice our strong support for the development of an All-Payer Claims Database (APCD) in Virginia.

We all know that health care costs are too great and growing too quickly. However, we cannot improve what we cannot measure and assess. The informatics and analysis made possible by an APCD will significantly advance the Commonwealth's, businesses', consumers', health care providers' and payers' ability to make critical improvements in health care quality as well as control the growth of health care costs.

The lack of widely available health care cost information is astounding, especially given the amount of data that is actually generated. While physicians at SMG know the outcomes of the individual patients we treat, it has only been through a concerted effort on the part of the practice and Sentara Healthcare as a whole that we are able to truly quantify the quality of the care we provide and to make targeted improvements based on that information. We post this quality information online and at the entrance to each of our facilities. This is a step in the right direction, but it is still not enough. Like all providers around the state, we can and must do more. We need better data to do so.

Patients receive care from a variety of sources and move between insurance plans regularly. Quality varies between providers and even between different facilities of the same provider. Trends in utilization, outcome and payment are impossible to discern because we lack comprehensive, accessible information. As a result, we cannot make all of the substantive improvements in quality and costs that we should. An APCD in Virginia will provide a wealth of data that can facilitate care quality improvement and cost reduction.

Like any worthy innovation, APCDs raise questions. Other states have implemented APCDs in various ways, and Virginia can draw several lessons from our counterparts:

- Confidentiality and security of data has been a primary concern in every state and through the careful application of technology, it can be sustained.
- Many states have created their APCDs as an adjunct to existing inpatient discharge databases. Virginia Health Information has done an admirable job of stewarding these data for more than a decade; an APCD is a natural extension of their current charge.

The largest question left to be answered is how to present claims data in a manner that is meaningful to all users without creating instability in the system. Several models exist, and the General Assembly, the Board of Health and the governing board of VHI (which includes strong representation from stakeholder organizations) are certainly capable of making these data use decisions in a manner that best suits the needs of Virginia's consumers, businesses, providers and payers, and the Commonwealth itself.

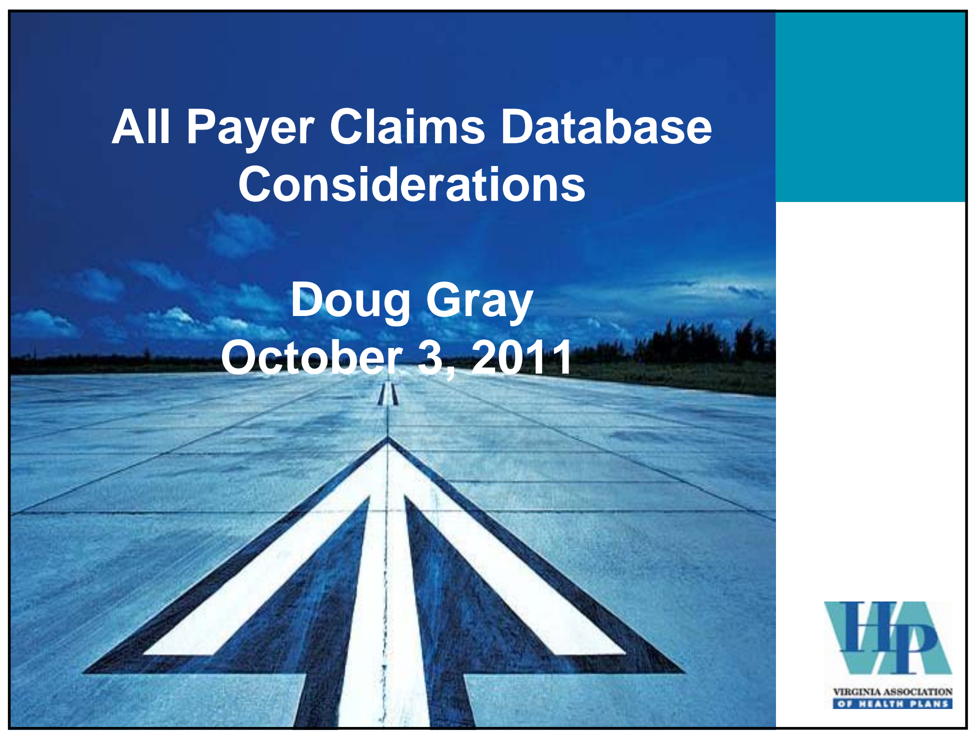
We need to improve health care quality and reduce costs in Virginia. We've all talked about this issue as a matter of public policy. Many of us have talked about it at the kitchen table because it impacts our families. It's time to take the next step on the path to improvement. Establishing an APCD is not a panacea, but represents an important tool to make sorely needed progress. There are details left to be worked through, but we must move forward and establish an APCD in Virginia.

Thank you for your attention to this important issue.

Sincerely,

David R. Maizel, M.D. ABFP, FAAFP
CVP & President

DRM/bw

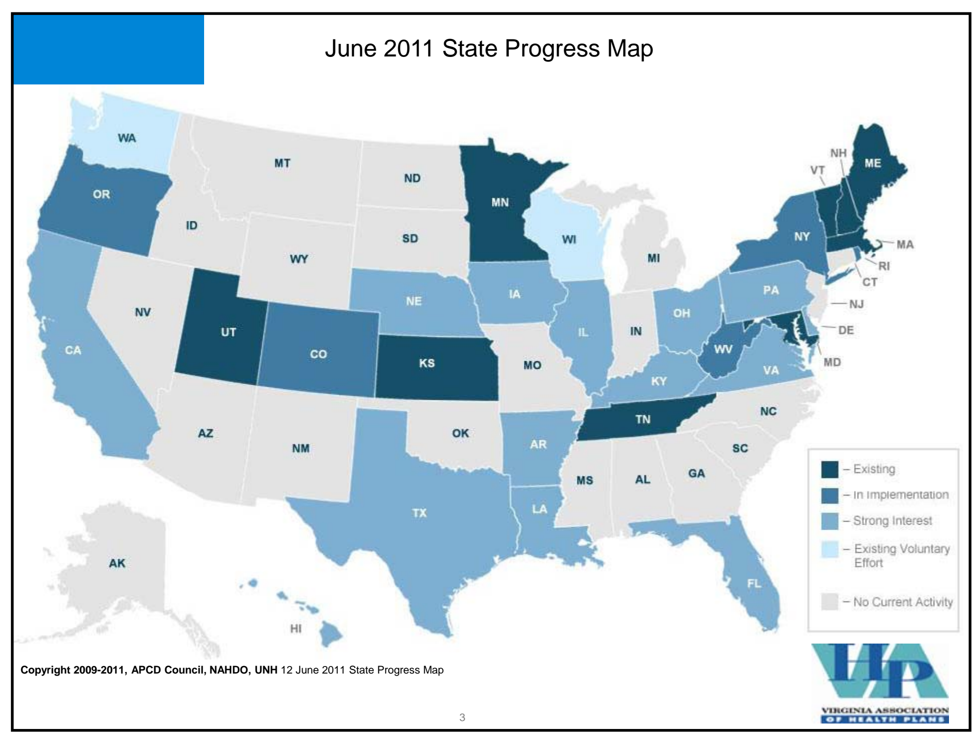


All Payer Claim Databases (APCDs) What Are They?

APCDs aggregate payer claim and related information into databases used by state agencies to produce information on:

- costs & quality
- utilization patterns
- access and barriers to care

APCDs may collect eligibility, provider and product information in addition to claim data.



Relationship to Health Information Exchanges

- HHS is funding state initiatives to create Health Information Exchanges. Virginia was awarded $11.6 million to further develop the states HIE which will permit collection of clinical data from providers for research and analysis
- States may use the clinical data provided by state HIEs combined with payer data to allow for analysis of both cost and quality

Examples of HIE Reports

- The HIE will provide services to enable electronic public health reporting, quality reporting, immunization reporting, reportable lab results and surveillance data.
- Public health measures from the HIE include:
  - Chronic disease registries vs. targets
  - Preventable hospitalization: pediatric asthma, heart failure, and diabetes
  - Health Maintenance registries vs. targets
  - Screening rate: breast cancer, colorectal cancer, cervical cancer
  - Percent of organizations sharing public health, quality management and medication management information
  - Compare exchange vs. non-exchange organizations

What should be considered when setting up the APCD?

- Use a consistent set of data elements
- Collect data from the source most likely to have it as part of the normal course of business
- Weigh the value of the data element collected against the cost involved in payer collection and provision of the data
- Include all stakeholders in the drafting of the legislation and in the development of data collection standards and procedures
- Establish a standard schedule for data requirement additions/changes
- Implement strong privacy and security safeguards to protect against inappropriate disclosure and use of data

Use a consistent set of data elements

The advantages of using standard datasets across states include:

- Carrier familiarity with the standard datasets means less time to get set up, and more reliable data
- Lower cost to carriers supporting more than one state's APCD since programs can be adapted from other states, saving IT time and money
- Use of programming developed by other states for common research questions meaning less time and expense to produce usable information
- Established standards by the ANSI X12 organization will mean states can point to the standards in their regulations

New York's Technical Tiger Team

- Looking to leverage existing state data stores for information that carriers don't normally collect, saving time and money

Collect data from the source most likely to have it as part of the normal course of business

Questions to Ask

Is it needed to:

- pay a claim?
- enroll a member/subscriber?
- bill a member/subscriber?

If so, a Payer should have this data.

If not, another entity may be a better resource for the data.

Weigh the value of the data element collected against the cost involved in payer collection and provision of the data

Need to ask: Is the cost for retrieving the data justified by how the data will be used?

Costs

- Payer systems collect and store data needed to support core business needs; not all data on claim forms may be stored/reportable
- Adding data elements to systems can be costly – $1 million or more
- Storage costs for data elements not needed for core business can be substantial (450 million claims processed a year)

Benefits

- Measurable improvement in quality of care for state residents
- Greater transparency in health care
- Overall cost savings in the health care system

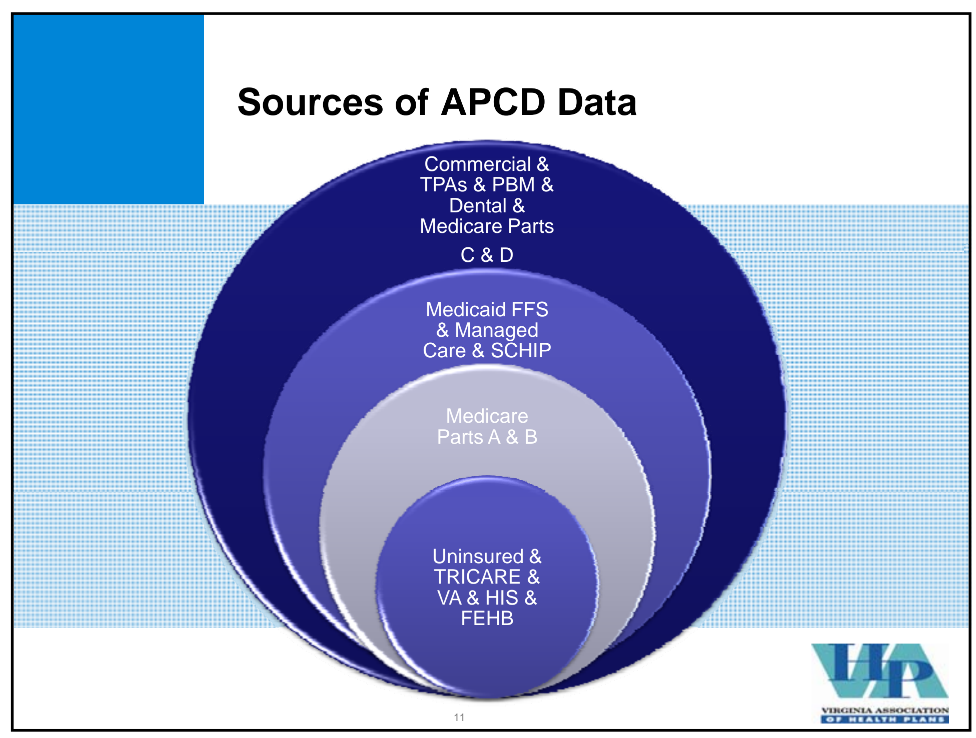
Include all stakeholders in the drafting of the legislation and in the development of data collection standards and procedures

Who are the stakeholders?

- Entities which collect needed data in the normal course of business
- Potential users of the data

Others who should be resources?

- States considering or just beginning their data collection efforts
- States where ACPDs are established
- Organizations that have been involved in creating and maintaining ACPDs in other states.



Establish a standard schedule for data requirement additions/changes

- Payers must plan for changes well in advance
- Payer system release procedures control which system changes are funded and resourced and when changes go into the system
- Release schedules and funding/assignment of resources may be developed early in the previous year
- System changes may be frozen during open enrollment periods (Typically around Jan.1 or July 1 enrollment.)

Implement strong privacy and security safeguards to protect against inappropriate disclosure and use of data

- Individuals expect that their state government will protect their personal information
- Individuals rely on payers (health plans) to handle Protected Health Information as required by state and federal law
- Moving vast quantities of data and aggregating data that still may identify individuals is high risk

APCD Uses

APCD uses include:

Health Care Transformation

- Evaluation of Care Coordination – to avoid waste and over/under utilization of services and to improve patient health outcomes
- Quality Measurement and Improvement – to maintain what is good about existing care while focusing on areas needing improvement
  - Example: Study of Medicare expenditures for patients with chronic diseases

Comparative Effectiveness

- To compare a variety of treatment options to determine best outcomes under what circumstances
  - Example: Appropriateness study on angioplasty and coronary artery bypass grafts for certain conditions.

Other Considerations

Will the use of an ACPD drive down costs by providing something that insured individuals do not have access to currently?

- Many payers already provide information to members on the actual cost the member may expect to pay for a specific procedure
- Insureds with lower cost-sharing requirements who may pay the same no matter where they go do not have an incentive to look for the best price.
- The implementation of additional federal health reform changes will create increased standardization in benefit packages and cost-sharing; this may reduce consumer incentives to be wise consumers of their health care dollars.

Recommend: Focusing on clinical data to improve quality and health outcomes.

Other Considerations (cont.)

General:

- Does the Commonwealth have jurisdiction to collect data from self insured; uninsured; and those covered by government programs?
- Where will an APCD be housed and how will it be funded?
- What lines of business will be included – should plans that are limited or have transient enrollees be excluded (i.e. student plans; limited benefit plans; specific illness plans)?

Note:

- APCDs rely on monthly submissions of health care claims, with an average lag time of 6-9 months from the date of service. This means they are not useful for "real-time" data needs, such as supporting the operations of ACOs.
- States find it challenging to create consolidated, accurate provider files to allow provider comparisons; reconciling provider identifiers from multiple carriers may be time consuming and may result in many errors.

FROM NUMBERS TO KNOWLEDGE
VHI
VIRGINIA HEALTH INFORMATION
All Payer Claims Databases (APCDs)
VHI Background & Key Considerations
Michael Lundberg, Executive Director
October 3, 2011

FROM NUMBERS TO KNOWLEDGE
VHI
VIRGINIA HEALTH INFORMATION
VHI Background
-Organizational Structure
-Mission
-Information Collected
-Publications & Databases
-Funding
Building a Value-Driven APCD
-Funding
-Standardization
-Transparency
-Phased Implementation
-Build on Success

Our Mission

To create and disseminate health care information

To promote informed decision making by Virginia consumers and purchasers,

To enhance the quality of health care delivery

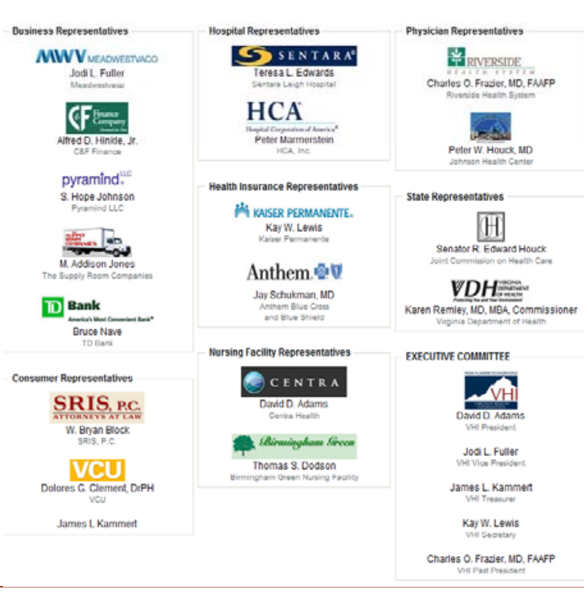
Background- Who we are

VHI is an independent, not-for-profit, 501(c)(3) health information organization established in 1992.

- Board of Directors represents Virginia health care stakeholders
- Formed to administer Virginia Health Care Data Reporting Initiatives to benefit Virginians § 32.1-276.2

Representing All Health Care Stakeholders To Benefit Consumers, Business and others

- Since inception, VHI's Board of Directors recognized the value of multi-stakeholder collaboration.
- By-laws stipulate the Board of Directors will include seven health care stakeholder groups.
- Inclusive structure and member Involvement results in credibility, financial diversity, and recognition as a trusted, independent intermediary.



Information Collected and Funding Sources

Type of Data	Funding Sources	Uses
Hospital Patient Level Data, Outpatient Data	General Funds and VHI.	Consumer, business reports, (heart care, obstetrics, etc) public health , research
EPICS-financial and operational	Ambulatory Surgical Centers, Hospitals, Nursing Facilities	Public reports on efficiency, productivity, financial health, charity care, average cost per admission etc.
HMO quality and financial performance information	HMOs	Quality, satisfaction and premium (PPMPM) information for business and consumers
Long Term Care information on costs and quality	VHI and leveraged data from EPICS	LTC Guide, costs and Nursing facility quality
Annual Licensure Survey	VDH Office of Licensure and Certification fees	Certificate of Public Need, utilization. Public reports
Prices for health care services	VHI	Public reports on average allowed amounts for 31 services

VHI Publishes Business and Consumer Guides, Reports, and Information
VHI
Consumer Costs for MRI, Knee and Shoulder Surgery
Health Plan Satisfaction Rates and Premiums
C-Section Rates for Doctors and Hospitals
Consumer Guides to Health Insurance, Hospitals, Long Term Care
Assisted Living, Home Health Facility Prices and Location
Nursing Home Costs and Quality
Hospital Patient Satisfaction Rates
Hospital Heart Surgery Mortality and Readmission Rates
Efficiency Ratings for Ambulatory Surgical Centers, Hospitals, Nursing Homes
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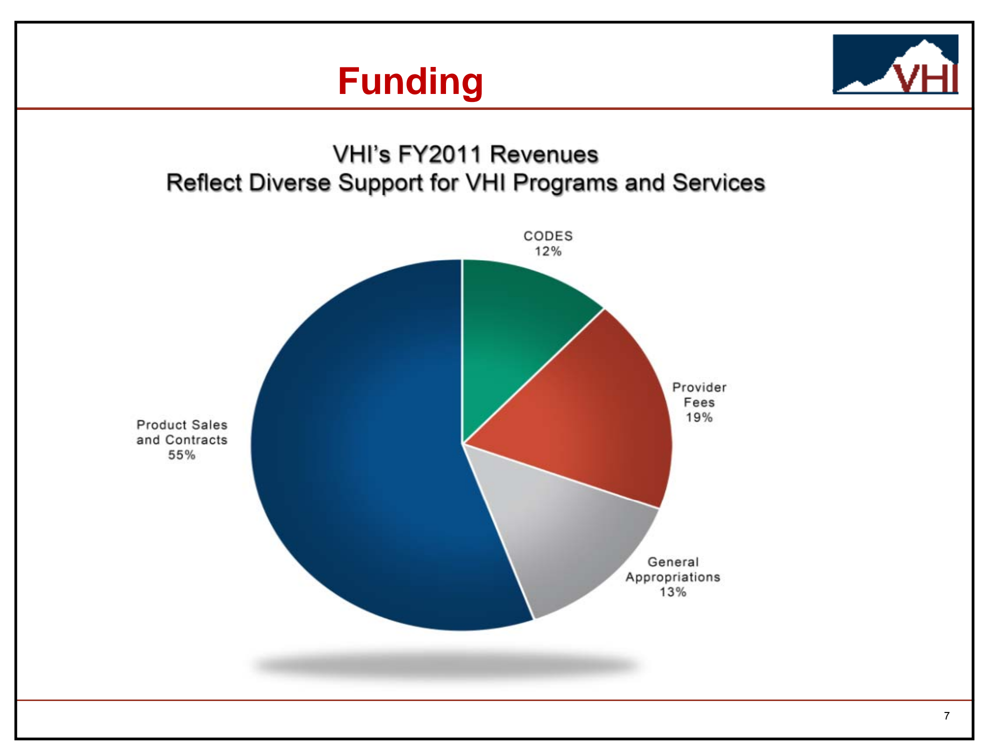

Funding
VHI
VHI's FY2011 Revenues
Reflect Diverse Support for VHI Programs and Services
CODES 12%
Provider Fees 19%
General Appropriations 13%
Product Sales and Contracts 55%
7

Some Definitions

- **All Payer Claims Database**: A database of medical, pharmacy, and dental claims, member eligibility, provider, and product files encompassing fully-insured, self-insured, Medicare, and Medicaid data.
- **Health information exchange:** (HIE) the transmission of healthcare-related (clinical) data among facilities, providers and government agencies
- **Health Benefits Exchange:** A resource for Americans seeking health insurance. Under the Patient Protection and Affordable Care Act of 2010. Individual insurance buyers can select any of a variety of plans within the Exchange all of which are administered by private insurance companies.

Other States are planning to integrate these

VHI

CER studies; supplement HIE with APCD transactions; etc.

APCD (administrative)

Rate review; MLR review; product /benefit design; etc.

Shared Services

HIE/HIO (clinical)

HBE/HIX (insurance)

Relationship studies between benefits and care delivery; quality rankings for HBE/HIX; etc.

APCD Funding – State Funding Models

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

Need for Standardization

- 14 States have/are implementing APCDs
- Historically, health insurance carriers were asked to provide information differently state-by-state causing
  - Unfair and unnecessary cost burden to carriers
  - Difficulty in comparing care across state lines
- National Standards are needed to address these problems.
  - Standards for reporting have been drafted for adoption by standards organizations
  - If an APCD is developed in Virginia, adoption of these standards is an important component for success

Transparency- A Key to Value

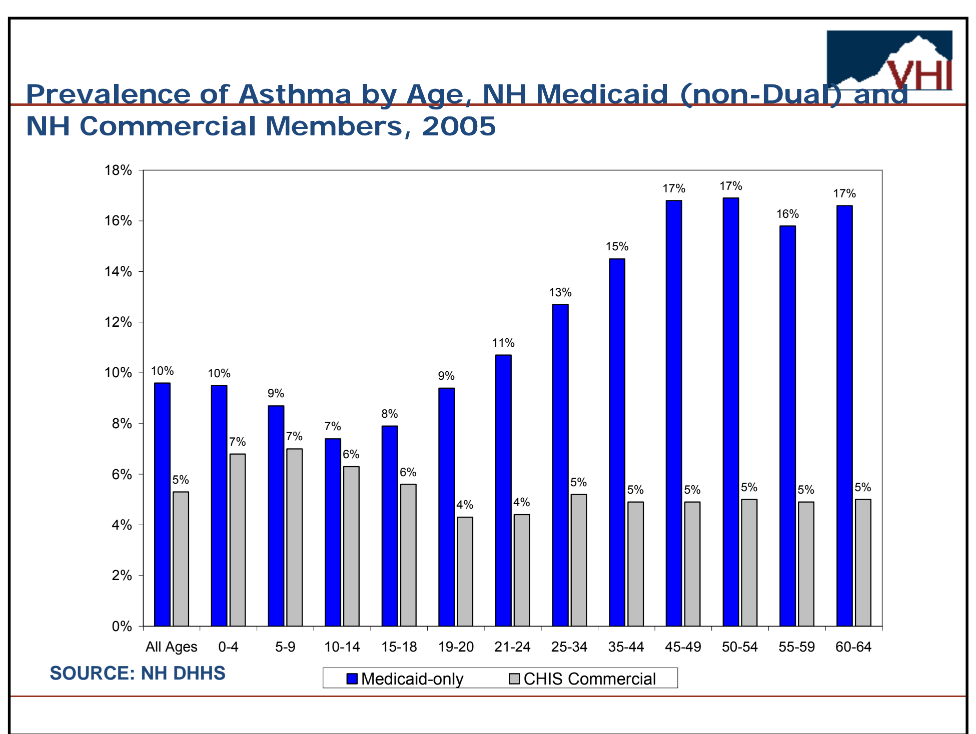
When unrestricted, APCDs have something for everyone…

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

Examples follow next 8 slides

VHI

Prevalence of Asthma by Age, NH Medicaid (non-Dual) and NH Commercial Members, 2005



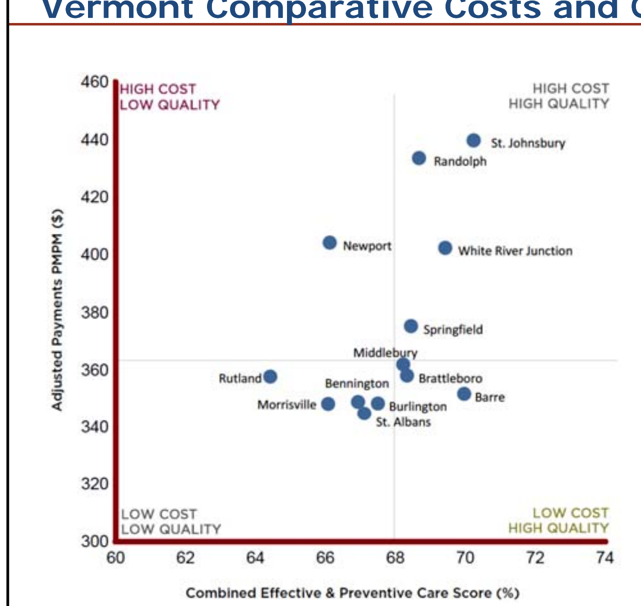
SOURCE: NH DHHS

Selected Prevalence Conditions – Vermont Commercial Population – 2007-2009

Major Disease Category	Rate/1,000 Members	Rate/1,000 Members	Rate/1,000 Members
	2007	2008	2009
Cancers			
Breast Cancer	6.3	6.3	6.6
Lung Cancer	1	1	1
Colorectal Cancer	1.2	1.1	1.2
Digestive System Diseases	101	99.5	101.1
Heart & Other Circulatory Diseases			
Coronary Heart Disease	13.2	12.9	13.5
Stroke	4.8	4.9	5.2
Congestive Heart Failure	2.3	2.3	2.2
Genitourinary System Disorders	160.5	156.3	156.0
Respiratory System Disorders	263.3	255.5	261.1

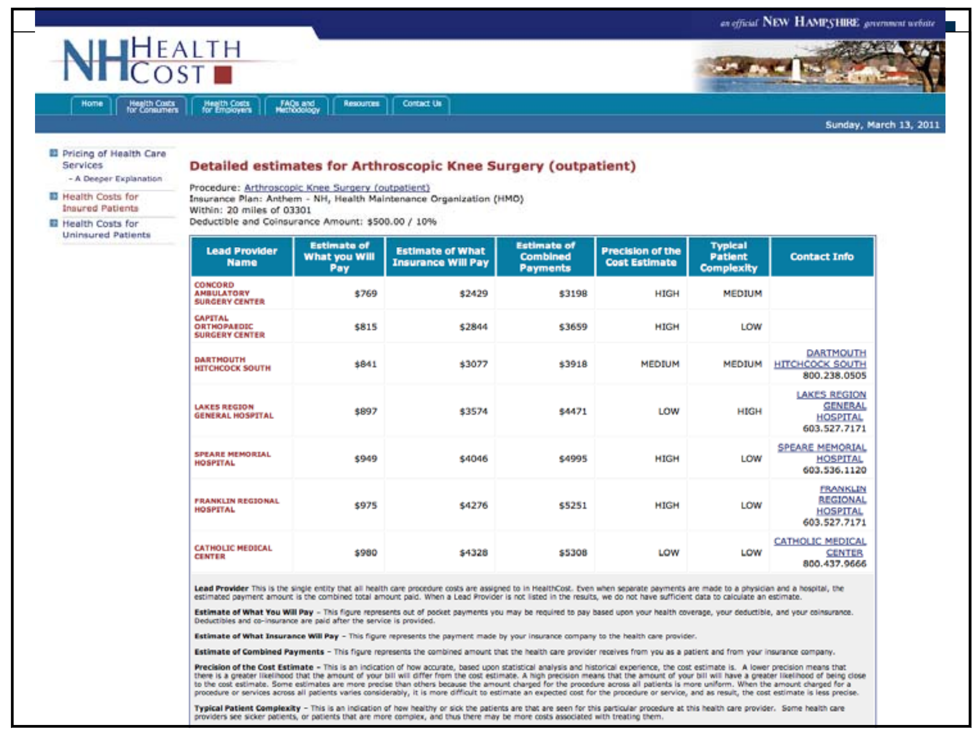
SOURCE: VT BISHCA

Vermont Comparative Costs and Quality by Region



The scattergraph shows the relationship between the rate of payments and the rate of effective and preventive care. The graph's vertical axis displays the rate of payment per member per month (PMPM) adjusted for differences in age, gender, and health status of the population. The graph's horizontal axis displays the combined effective and preventive care score. The crosshair lines display the statewide average for each axis; subpopulations are classified into quadrants based on comparison to the statewide average.

SOURCE: VT BISHCA



an official NEW HAMPSHIRE government website

NH HEALTH COST

Home | Health Costs for Consumers | Health Costs for Employers | FAQs and Methodology | Resources | Contact Us

Sunday, March 13, 2011

- Pricing of Health Care Services
  - A Deeper Explanation
- Health Costs for Insured Patients
- Health Costs for Uninsured Patients

Detailed estimates for Arthroscopic Knee Surgery (outpatient)

Procedure: Arthroscopic Knee Surgery (outpatient)
Insurance Plan: Anthem - NH, Health Maintenance Organization (HMO)
Within: 20 miles of 03301
Deductible and Coinsurance Amount: $500.00 / 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
CONCORD AMBULATORY SURGERY CENTER	$769	$2429	$3198	HIGH	MEDIUM	
CAPITAL ORTHOPAEDIC SURGERY CENTER	$815	$2844	$3659	HIGH	LOW	
DARTMOUTH HITCHCOCK SOUTH	$841	$3077	$3918	MEDIUM	MEDIUM	DARTMOUTH HITCHCOCK SOUTH 800.238.0505
LAKES REGION GENERAL HOSPITAL	$897	$3574	$4471	LOW	HIGH	LAKES REGION GENERAL HOSPITAL 603.527.7171
SPEARE MEMORIAL HOSPITAL	$949	$4046	$4995	HIGH	LOW	SPEARE MEMORIAL HOSPITAL 603.536.1120
FRANKLIN REGIONAL HOSPITAL	$975	$4276	$5251	HIGH	LOW	FRANKLIN REGIONAL HOSPITAL 603.527.7171
CATHOLIC MEDICAL CENTER	$980	$4328	$5308	LOW	LOW	CATHOLIC MEDICAL CENTER 800.437.9666

Lead Provider This is the single entity that all health care procedure costs are assigned to in HealthCost. Even when separate payments are made to a physician and a hospital, the estimated payment amount is the combined total amount paid. When a Lead Provider is not listed in the results, we do not have sufficient data to calculate an estimate.

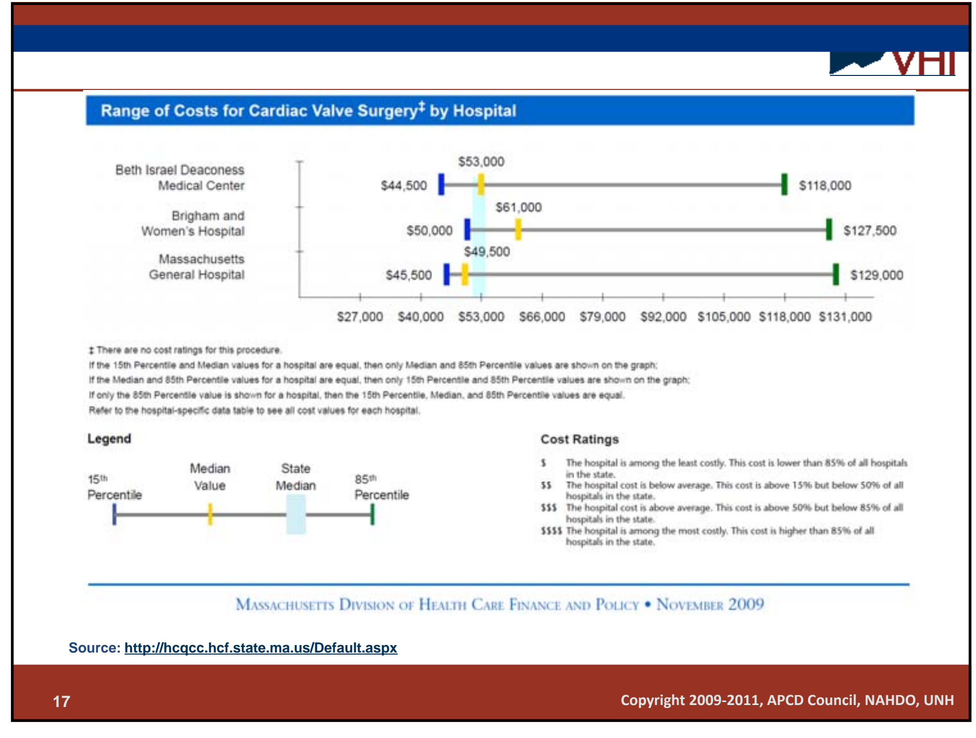
Estimate of What You Will Pay – This figure represents out of pocket payments you may be required to pay based upon your health coverage, your deductible, and your coinsurance. Deductibles and co-insurance are paid after the service is provided.

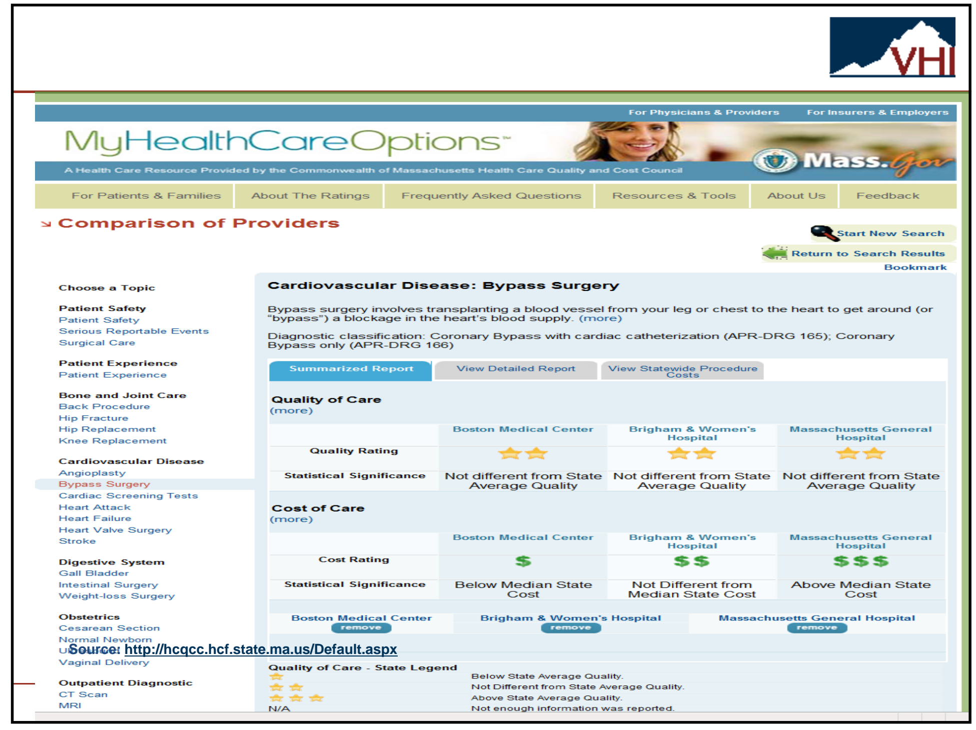
Estimate of What Insurance Will Pay – This figure represents the payment made by your insurance company to the health care provider.

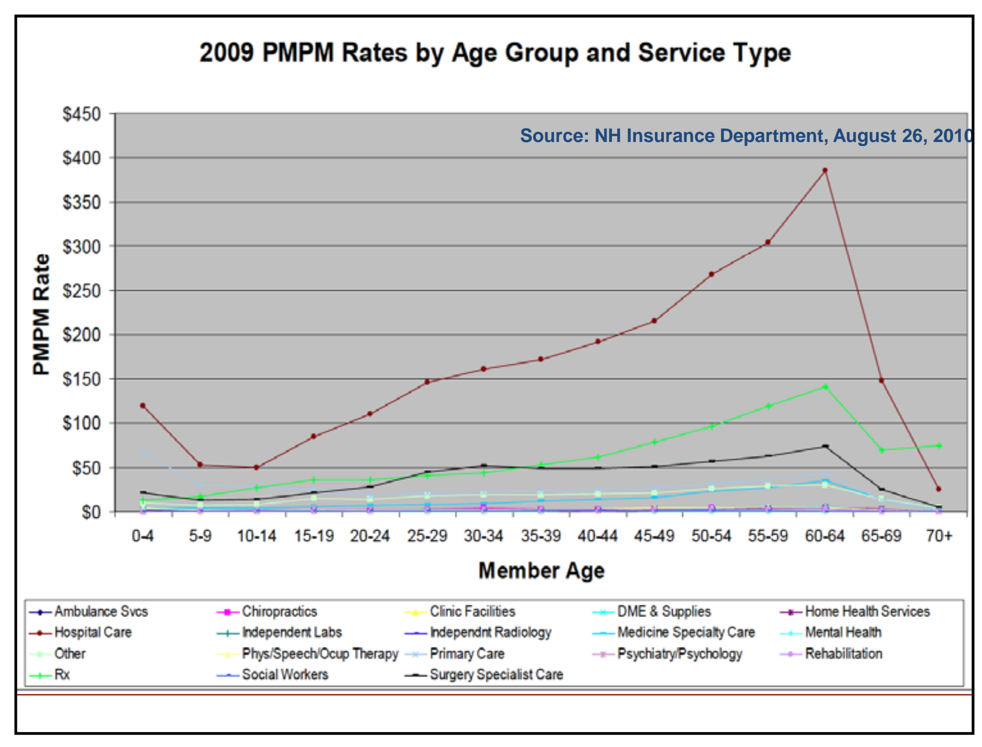
Estimate of Combined Payments – This figure represents the combined amount that the health care provider receives from you as a patient and from your insurance company.

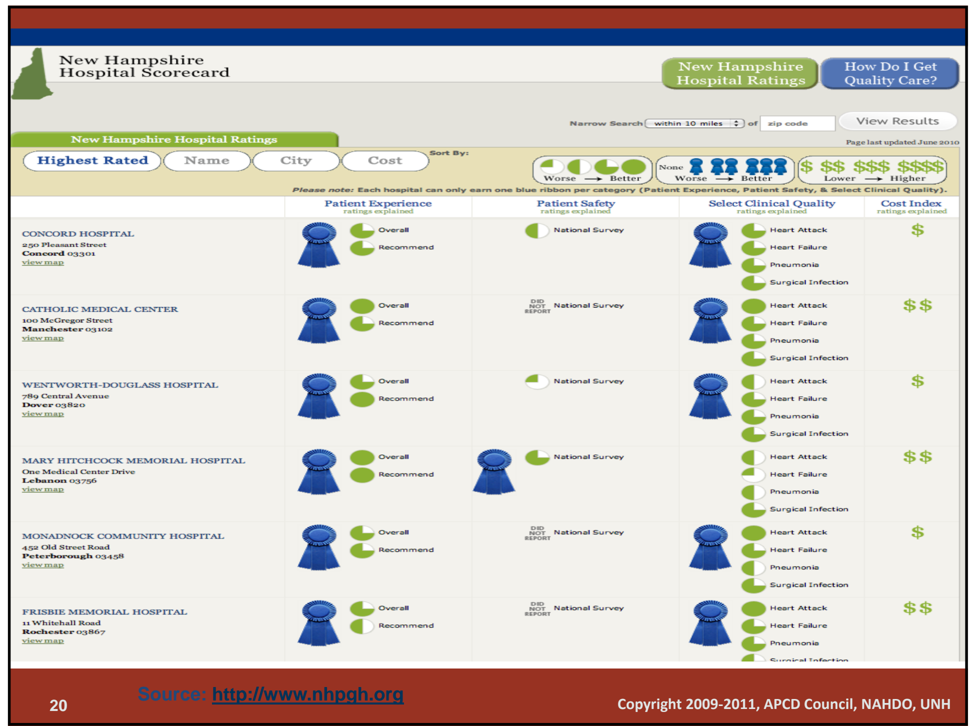
Precision of the Cost Estimate – This is an indication of how accurate, based upon statistical analysis and historical experience, the cost estimate is. A lower precision means that there is a greater likelihood that the amount of your bill will differ from the cost estimate. A high precision means that the amount of your bill will have a greater likelihood of being close to the cost estimate. Some estimates are more precise than others because the amount charged for the procedure across all patients is more uniform. When the amount charged for a procedure or services across all patients varies considerably, it is more difficult to estimate an expected cost for the procedure or service, and as result, the cost estimate is less precise.

Typical Patient Complexity – This is an indication of how healthy or sick the patients are that are seen for this particular procedure at this health care provider. Some health care providers see sicker patients, or patients that are more complex, and thus there may be more costs associated with treating them.




VHI
For Physicians & Providers
For Insurers & Employers
MyHealthCareOptions
A Health Care Resource Provided by the Commonwealth of Massachusetts Health Care Quality and Cost Council
Mass.Gov
For Patients & Families
About The Ratings
Frequently Asked Questions
Resources & Tools
About Us
Feedback
Comparison of Providers
Start New Search
Return to Search Results
Bookmark
Choose a Topic
Patient Safety
Patient Safety
Serious Reportable Events
Surgical Care
Patient Experience
Patient Experience
Bone and Joint Care
Back Procedure
Hip Fracture
Hip Replacement
Knee Replacement
Cardiovascular Disease
Angioplasty
Bypass Surgery
Cardiac Screening Tests
Heart Attack
Heart Failure
Heart Valve Surgery
Stroke
Digestive System
Gall Bladder
Intestinal Surgery
Weight-loss Surgery
Obstetrics
Cesarean Section
Normal Newborn
Vaginal Delivery
Outpatient Diagnostic
CT Scan
MRI
Cardiovascular Disease: Bypass Surgery
Bypass surgery involves transplanting a blood vessel from your leg or chest to the heart to get around (or "bypass") a blockage in the heart's blood supply. (more)
Diagnostic classification: Coronary Bypass with cardiac catheterization (APR-DRG 165); Coronary Bypass only (APR-DRG 166)
Summarized Report
View Detailed Report
View Statewide Procedure Costs
Quality of Care
(more)
Boston Medical Center
Brigham & Women's Hospital
Massachusetts General Hospital
Quality Rating
Statistical Significance
Not different from State Average Quality
Not different from State Average Quality
Not different from State Average Quality
Cost of Care
(more)
Boston Medical Center
Brigham & Women's Hospital
Massachusetts General Hospital
Cost Rating
$
$$
$$$
Statistical Significance
Below Median State Cost
Not Different from Median State Cost
Above Median State Cost
Boston Medical Center
remove
Brigham & Women's Hospital
remove
Massachusetts General Hospital
remove
Source: http://hcqcc.hcf.state.ma.us/Default.aspx
Quality of Care - State Legend
Below State Average Quality.
Not Different from State Average Quality.
Above State Average Quality.
N/A
Not enough information was reported.


2009 PMPM Rates by Age Group and Service Type
Source: NH Insurance Department, August 26, 2010
PMPM Rate
$450
$400
$350
$300
$250
$200
$150
$100
$50
$0
0-4
5-9
10-14
15-19
20-24
25-29
30-34
35-39
40-44
45-49
50-54
55-59
60-64
65-69
70+
Member Age
Ambulance Svcs
Chiropractics
Clinic Facilities
DME & Supplies
Home Health Services
Hospital Care
Independent Labs
Independnt Radiology
Medicine Specialty Care
Mental Health
Other
Phys/Speech/Ocup Therapy
Primary Care
Psychiatry/Psychology
Rehabilitation
Rx
Social Workers
Surgery Specialist Care



Phased Implementation

Consider starting with population health measures. Align priorities with VDH programs, high variation conditions, and /or costs. Examples:

- Diabetes: rates of good control: Variations by region/city/ commercial compared to government programs
- Timeliness of prenatal care- related to low infant birth weight
- Follow-up after hospitalization For mental Illness within 7 days after hospital discharge
- Proper medications following heart attack (persistent use of beta blockers)

Phased Implementation-continued

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- Support Health Benefits Exchange with information on health care utilization and costs.
- Provide information to support emerging accountable care organizations
- Expand pricing transparency to regional variations. Work with stakeholders to expand detail to provider and payer
- Depending on HIE participation levels by consumers and providers evaluate potential to add clinical lab/radiology/other information from HIE to support quality improvement efforts and public reporting on costs and quality

Build on Success: Leverage Existing Health Data Reporting laws

Many aspects regarding administration of an APCD including, fees, confidentiality, data release and related issues have been previously addressed and can be altered to address an APCD

Code Of Virginia Chapter 7.2 - Health Care Data Reporting

32.1-276.2 Health care data reporting; purpose

32.1-276.3 Definitions

32.1-276.4 Agreements for certain data services

32.1-276.5 Providers to submit data

32.1-276.5:1 Disclosures of contractual arrangements to be made publicly available.

32.1-276.6 Patient level data system; reporting requirements 32.1-276.8 Fees for processing, verification, and dissemination of data

32.1-276.9 Confidentiality, subsequent release of data and relief from liability for reporting; penalties

A Fork in the Road ?

Thoughts on a Value-Driven APCD

Funding Model: Consider multi-stakeholder approach

Standardization: To reduce carrier burden

Transparency: To increase value to all

Phased Implementation: Based on Virginia priorities

Build on Success: Leverage existing Virginia Code

All-Payer Claims Databases

Joint Commission on Health Care

Stephen W. Bowman
Senior Staff Attorney/Methodologist

October 17, 2011

Significant variation exists in health care costs, inflation, and quality by location

Fact 1: Virginia's 2004 per capita health care costs are lower than the U.S. ($4,822 vs. $5,283)

Fact 2: Virginia's annual health care inflation rate from 1991-2004 is higher than the U.S. average (5.6% vs. 5.5%)

Fact 3: Virginia health care sectors' annual inflation from 1991-2004

- Rx with medical non-durable expenses had the highest increases of 8.4%
- Hospital Care was lowest at 4.6%

Fact 4: Preventable hospital readmissions in Virginia differ by geography

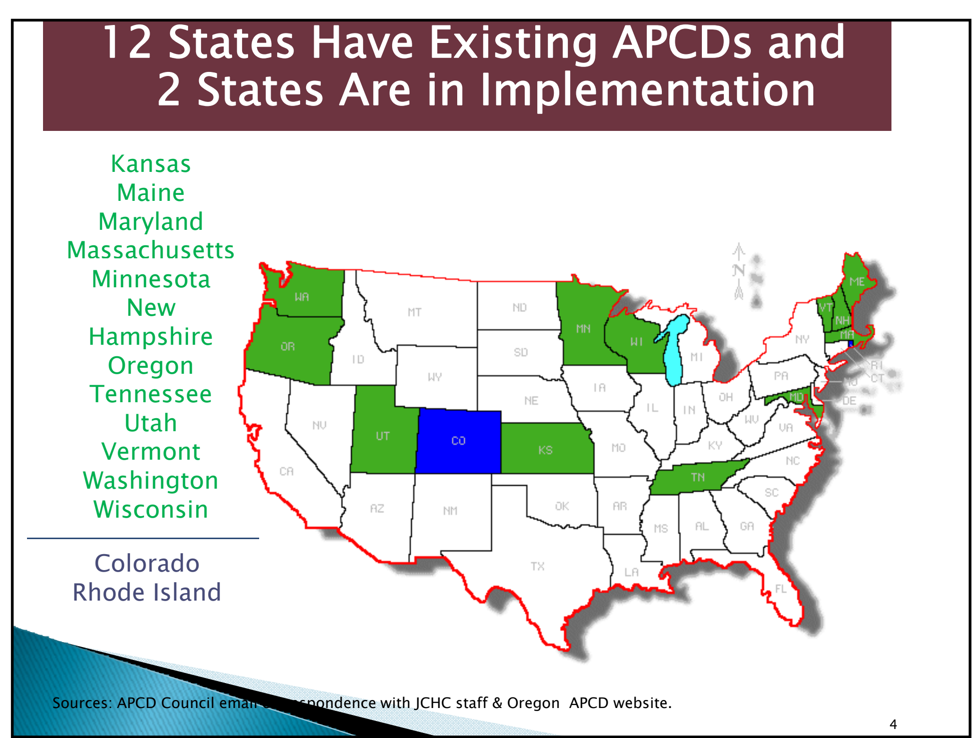
Fact 5: More expensive health care does not yield higher quality

What Is an All-Payer Claims Database?

- Databases that typically include data derived from medical, eligibility, provider, pharmacy, and/or dental claims from private and public payers:
  - Insurance carriers
    - Medical, dental, third party administrators (TPAs), pharmacy benefit managers (PBMs)
  - Public payers
    - Medicaid, Medicare, Veterans Administration
- APCDs can allow for a broad understanding of cost and utilization across institutions and populations

Source: Slide from NAHDO Annual Conference, October 2009 Patrick Miller, MPH Research Associate Professor, University of New Hampshire (revised by JCHC staff).

3



APCDs Can Answer Many Types of Health Care Questions

Cost

Which hospitals, surgical centers or doctors have the lowest prices by procedure, or treatment?

What do health insurance companies pay for health care services?

Access

How far do people travel for services and for what type of services?

Medicaid

Is emergency room usage in Medicaid higher than the commercial population? What are the possible reasons?

Quality

- Which hospitals, surgical centers or doctors have the highest ratings for certain medical procedures?
- Are established clinical guideline measurements related to quality, safety, and continuity of care being met?

Public Health

- What are the key public health issues by city and county?
- In what geographic areas is public health improving?

Sources: Slide content [illegible] Alan Prysunka presentation to Virginia Health Reform Initiative Technology Task Force November 16, 2010 & Patrick [illegible] Denise Love, Emily Sullivan, Jo Porter and Amy Costello, All-Payer Claims Databases: An Overview for Policymak[illegible] 2010.

APCD Primary Focus Varies Among States

	Cost	Quality	Efficiency	Geographic Differences	Episodes of Care	System Utilization
Kansas	■	■	■	■	■	■
Maine	■	■		■	■	■
Maryland	■		■	■		
Massachusetts	■					■
Minnesota	■	■		■	■	■
New Hampshire	■	■	■	■	■	■
Oregon	■					
Tennessee	■	■		■	■	■
Utah	■	■	■	■	■	■
Vermont	■	■		■	■	
Washington	■	■		■	■	■
Wisconsin	■	■	■		■	■

Other uses include: cost and quality benchmarking for Medicaid payment rates, measuring competition within the commercial health market, and potential risk adjustments.

Sources: APCD Council correspondence [illegible] staff & Tennessee APCD website.

Specific State–Uses for APCDs

- Help employers understand variations in the cost and utilization of services by geographic area and in different provider settings (ME, NH)
- Explore value (cost and quality) for services provided (NH)
- Inform design and evaluation plans for payment reform models (NH, VT)
- Evaluate the effect of health reforms on the cost, quality, and access to care in a state (MD, VT)
- Compare utilization patterns across payers to inform state purchasing decisions for Medicaid (NH) and identify successful cost containment strategies (NH, VT)

Source: Patrick Miller, Denise Lo[illegible] Emily Sullivan, Jo Porter and Amy Costello, All-Payer Claims Databases: An Overview for Policymake[illegible] 2010.

Important APCD Elements

- APCD Governance
- APCD Focus
- Data collection
  - Mandated submission?
  - Which payers submit data?
  - Does data include patient identifier information?
- Data release rules
- Public dissemination of data
- Funding

Many APCD permutations are possible

Sources: Denise Love, William Custer and Patrick Miller, All-Payer Claims Databases: State Initiatives to Improve Health Care Transparency, September 2010 & discussion with Michael Lundberg of VHI.

The HLHS Subcommittee Convened a Meeting Regarding a Virginia APCD

- October 3rd a APCD meeting was convened by the Healthy Living/Health Services Subcommittee
  - Members attending:
    - Delegate O'Bannon
    - Delegate Brink
    - Delegate Peace
    - Senator Barker
    - Senator Blevins
    - Senator Puller
  - Stakeholders presenting:
    - Virginia Association of Health Plans
    - Virginia Health Information
    - Virginia Hospital & Healthcare Association
- APCD principles were discussed; No votes were taken.

Potential Policy Options From APCD Meeting Discussion

Option 1: Take no action.

Option 2: Introduce legislation and accompanying budget amendment *(amount to be determined)* to amend Chapter 7.2 of Title 32.1 of the *Code of Virginia* to expand health data collected in order to develop an All-Payer Claims Database.

Option 3: By letter of the JCHC Chairman, indicate support for the creation of a Virginia All-Payer Claims Database. The letter would be sent to the chair of the following committees:

- Commerce and Labor (Senate and House)
- Education and Health (Senate)
- Health, Welfare and Institutions (House)

Option 3 represents general support for developing a Virginia APCD

Potential Policy Options from APCD Meeting Discussion

Option 4: Include in the legislation or Chairman's letter (if Option 2 or 3 is approved), specific attributes for the All-Payer Claims Database.

A. **Governance structure is housed at:**
   1. Virginia Health Information (VHI) or
   2. Another public or private entity other than VHI

B. **Types of data collected**
   1. Adhere to national reporting standards for medical claims (e.g. Accredited Standard Committee X12 standards when finalized)
   2. APCD will determine the required data elements

C. **Data collection from health insurers**
   1. Mandated collection
   2. Voluntary submission

Public Comment

- Written public comments on the proposed options may be submitted to JCHC by close of business on November 7, 2011. Comments may be submitted via:
  - E-mail: sbowman@jchc.virginia.gov
  - Facsimile: 804-786-5538
  - Mail to: Joint Commission on Health Care
P.O. Box 1322
Richmond, Virginia 23218
- The comments will be summarized and included in the Decision Matrix which will be discussed during the November 22nd JCHC meeting.

Joint Commission on Health Care
900 East Main Street, 1st Floor West
P. O. Box 1322
Richmond, VA 23218
804.786.5445
804.786.5538 (fax)

Website: http://jchc.virginia.gov