Healthcare Payments Data Program Review Committee

April 18, 2019

Office of Statewide Health Planning and Development

2020 W. El Camino Avenue, Sacramento, CA, 95813

Conference Room 900 A

OSHPD

Office of Statewide Health Planning and Development

Agenda

Item	Descriptions	Speaker
1.	Welcome and Meeting Minutes a. Introductions b. Review and Approval of March 21, 2019 Meeting Minutes	Ken Stuart, Chair, Review Committee
2.	Deputy Director's Report	Scott Christman, Chief Information Officer and Deputy Director, OSHPD
2.	Follow-Up from March 21 Meeting a. Presenting responses to Review Committee member questions from March 21 meeting b. Review of Updated Review Committee Topics Schedule	Ken Stuart, Chair, Review Committee
3.	Data Types: Presentation and discussion on claims and encounter data and non-claims-based payments information.	John Freedman, OSHPD Consultant & Jonathan Mathieu, OSHPD Consultant
4.	Use Cases: Discussion of framework for considering HPD use cases, including "tiers" for data collection and reporting; topics; audiences; and criteria for selecting use case examples. Review and discussion of specific use case examples.	Michael Valle, Chief Strategy Officer, OSHPD & Jill Yegian, OSHPD Consultant
5.	Public Comment	
6.	Agenda for Upcoming Review Committee Meeting & Adjournment	Ken Stuart, Chair, Review Committee

Deputy Director's Report

Scott Christman,

Deputy Director and Chief Information Officer,

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Follow Up from March 21 Meeting

Updated Healthcare Payments Data Program Review Committee Meeting Topics

March

Kickoff

- Welcome & Introductions
- Background on APCDs
- Goals for the Committee

April

Data Types and Use Cases

- Types of Data in the System
- Claims Data 101
- Use Case Categories
  - Cost & Utilization
  - Quality
  - Coverage & Access
  - Population Health
  - System Performance

May

Data Collection

- Data collection format options
- Streams of data collection (Medicare, Medicaid, Commercial)
- Data collection considerations in California's complex managed care environment

June

Enhancing Database Analytics

- What other relevant data sets can be linked to the HPD data system.
- Opportunities for additional enhancements to the database

July

Data Submitters

- Considerations of who will submit data to the database
- Differences between voluntary and mandatory submitters
- Requirements for frequency of data submission

Healthcare Payments Data Program Review Committee Meeting Topics

August	September	October	November	December
Data Quality	Data Governance and Privacy	Technology Alternatives	Governance: Administrative Plan for Operating the Database	Sustainability
• Roles and responsibilities in ensuring data quality throughout its lifecycle • Effective collaborations with submitters to ensure data quality • Documentation processes for data quality	• California privacy landscape • Privacy considerations for data collection, use and dissemination	• Technology options to receive, store, and structure data • Technology options to incorporate other data sets for research • Technology options to analyze data and publish reports	• Considerations for effectively governing a data management system • Opportunities to leverage existing data governance structures	• Discussion on associated costs of the database • Role of fees for data usage or data submission • Recommended business plan elements to fund the operations of the database

Data Collection Options for the CA Healthcare Payments Data Program

Freedman HEALTHCARE

Presentation to the

HPD Review Committee

April 18, 2019

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Freedman HealthCare and Multi-Payer Claims Databases

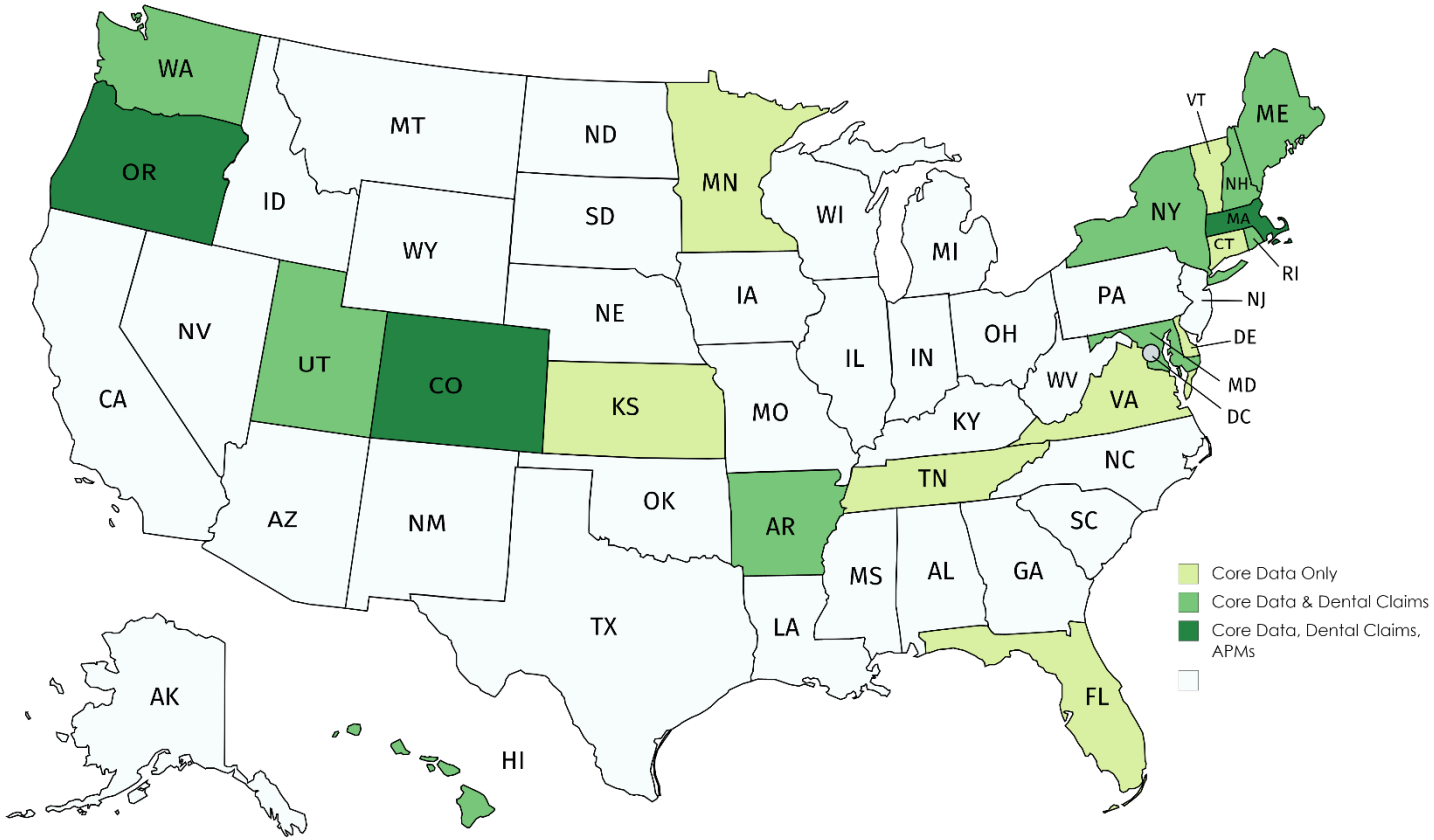
- Began MPCD/APCD advisory services in 2006
- Provide *nearly* the full range of services
  - Feasibility and stakeholder feedback
  - Legislation, regulations, governance
  - Vendor procurement, contracting, and oversight of implementation and vendor transition (if necessary)
  - Day-to-day database operations and project management, including data submitter relationship management
  - Reporting strategy, programmatic design
  - Custom analytics and dashboards
  - Data quality
  - Sustainability standards
  - NOT data intake or warehousing
- Clients include 19 states and a half dozen voluntary collaboratives
- Other work includes complex health project implementation, health policy analysis, operational support, and related activities
- For CA HPD, FHC team contributes insights and best practices drawn from hands-on, day-to-day technical and administrative experience

Today's Discussion: Payer Data Needed for HPD Use Cases

- What kinds of data do payers supply to APCDs?
  - Components, strengths, and challenges
- What are the Review Committee's concerns about collecting:
  - Claims and Encounter Data?
  - Alternative Payment Model (APM)/Non-Claims Data?
  - Other supplemental information?
- Are we using appropriate terminology and in the right ways for the CA health care market?

Claims and Encounter Data

State APCDs Collecting Core, Dental and APM Data



Claims and Encounter Data from "Health Payers"

- Health Payers usually include:
  - Commercial Insurance Plans, Pharmacy Benefit Managers
  - Medicaid – Fee for Service and Managed Care
  - Medicare – Fee for Service and Medicare Advantage

- Payers can also include:
  - Third-Party Administrators (TPAs)/Administrative Services Only (ASO) orgs.
  - Public Employee Plans, Associations and Trusts
  - Stand-alone plans, e.g., Dental, Vision, Student, etc.

- Mandatory payers typically do not include:
  - ERISA self-insured plans, including Taft-Hartley plans
  - Federal payers including FEHB, Tricare, the VA, and Indian Health Service
  - Small commercial plans – based on number of covered lives or gross revenue
  - Accident, Disability, Indemnity, Supplemental, Workers Comp, etc.

Four “Core” Data Files

- Member Eligibility
  - Information on all persons covered by a particular Health Payer
  - Includes details regarding the Payer, Health Plan, Subscriber/Members, Coverage Status, and Eligibility Time Spans
- Medical Claims and Encounters
  - Information on all services rendered or supplies provided
  - Includes details regarding the Payer, Provider, Patient/Member, Diagnoses, Procedures and Services Rendered, and Payment Details (claims only)
  - Encounters can include FFS-equivalents for capitated arrangements or ACO members
- Pharmacy Claims
  - Information on all prescription drugs, biologics and vaccines provided
  - Includes details regarding the Payer/Pharmacy Benefit Manager, Provider, Pharmacy, Patient, Drug Name/NDC Code, and Payment Details (claims only)
- Provider File
  - Information for all rendering/servicing, billing, and prescribing providers
  - Includes details regarding Name, Address/Location, Specialty, NPI, License #, Tax ID, etc.

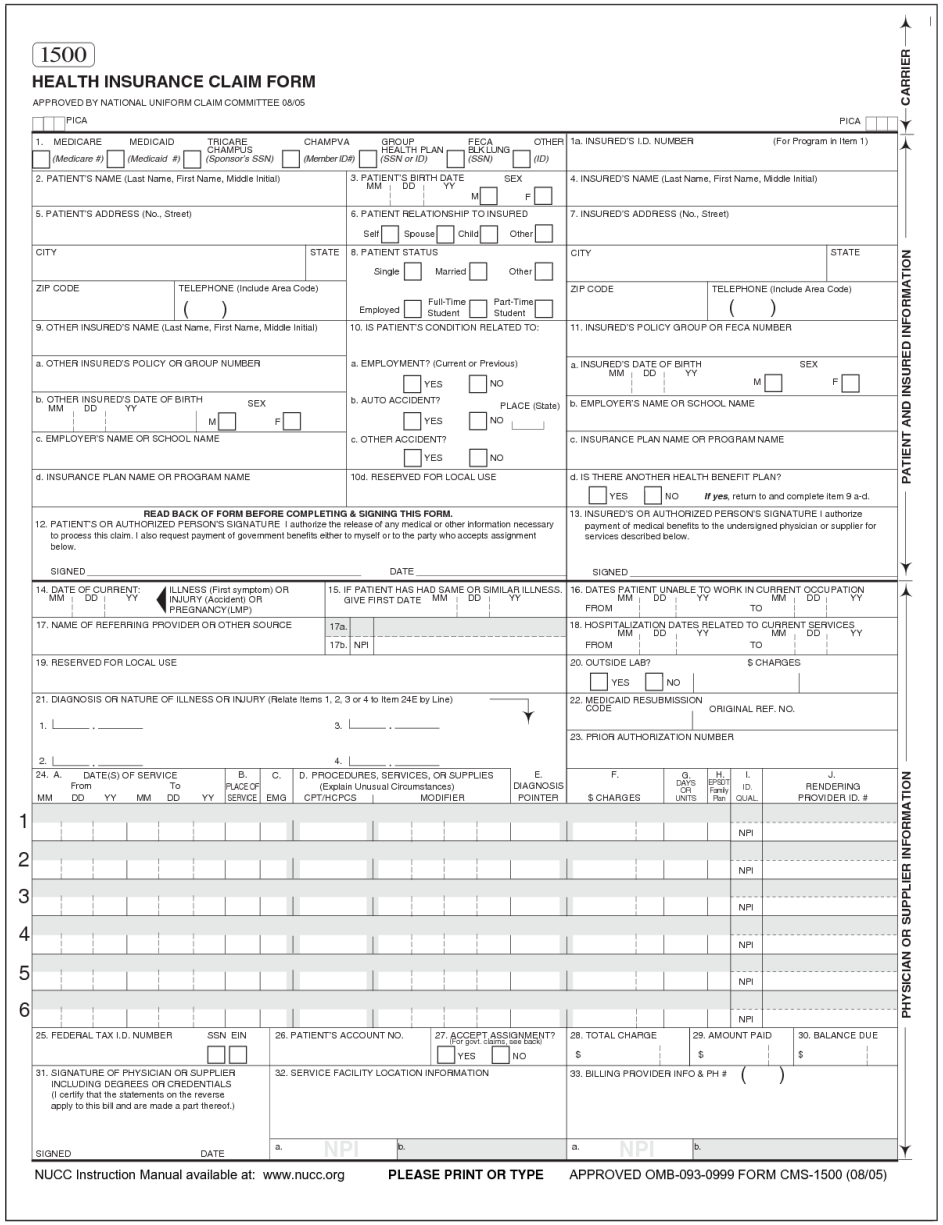
APCD Data Collection in Other States

	Commercial Payers	Medicaid Programs	Medicare FFS
Medical Services	Structured file format like "APCD-CDL™" for encounters and FFS claims	- Typically, Medicaid produces structured encounter and FFS claims files - Under discussion for HPD: Directly capture encounter transactions	Multiple CMS files for different service types. Not the "Core" data files
Eligibility	Structured file format like "APCD-CDL™"	Typically, Medicaid produces a structured file	CMS file format for Parts A, B, C, and D eligibility
Pharmacy Services	Structured file format like "APCD-CDL™"	Typically, Medicaid produces a structured file	Options: - CMS file format - Submissions from PBMs in a structured file format like "APCD-CDL™"
Provider Listing	Structured file format like "APCD-CDL™"	Typically, Medicaid produces a structured file	CMS file format or NPPES
Dental Services (collected by some APCDs)	Structured file format like "APCD-CDL™"	Typically, Medicaid produces a structured file	Dental services not covered under Medicare FFS

What Information is on a Claim?

On the claim itself:

- Patient and Provider identifiers
- Dates of service
- Location where service was provided
- Diagnosis codes
- Procedure codes
- Revenue codes
- Pharmacy codes
- Charges (Amounts Billed)



1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org **PLEASE PRINT OR TYPE** APPROVED OMB-093-0999 FORM CMS-1500 (08/05)

Charges vs. Allowed vs. Paid Amounts

Largely Irrelevant

Usually What We Want to Know

Patient Responsibility

What the Payer Paid

CHARGE	INSURANCE DISCOUNT	ALLOWED AMOUNT	COPAY (fixed)	COINSURANCE (%)	DEDUCTIBLE	INSURANCE PAYMENT
	$ 225	$ 275	$ 25	$ 0	$ 50	$ 200

Every Explanation of Benefits shows this information and is sent to the patient without restriction on disclosure.

The News on Claims Data

Claims data is intended to facilitate payment for services rendered, not to support secondary APCD or HPD analysis, reporting, and other uses

The Good

- Claims are standardized
- Claims are ubiquitous
- Claims cover nearly all health care services and supplies
- Claims are cheaply available
- Claims make analysis of health care simple!

The not so Good

- Despite the rules, “standardized” doesn’t mean fields are used in a consistent way
- Claims miss non-covered care and the uninsured
- Claims may miss ERISA plans and services covered by alternative payment models
- Claims lack clinical detail, particularly outcomes
- Managing non-standard claims gets expensive
- Claims are complicated!

Using Claims Data for Analysis and Reporting

- Supports:
  - Analysis of Cost both overall and at the service level – under FFS payment
  - Analysis of Utilization patterns and variation
  - Generation of process/procedural Quality measures
  - Payer and Provider-level Cost, Utilization, and Quality comparisons
- Limitations:
  - Gaps in Payment Information for Alternative Payment Models
    - Limited ability to analyze costs under non-FFS payment
    - Requires use of other data sources including APMs
  - Completeness:
    - Does not reflect services delivered to uninsured, self-pay and some insured individuals
    - Gaps in information on alternative payment models, carve outs, encounters, etc.
  - No Clinical Information:
    - Limited ability to support outcomes-based Quality measurement
    - Outcome measures, lab results, and other clinical data are necessary

Encounter Data: Similar to and Different from Claims Data

- Encounters:
  - Include most of the information found in claims
  - Are a record of services rendered under capitation or other value based arrangement between the payer and a provider
  - Are not a request for payment and typically lack details on amounts paid
  - Nationally, APCDs are evolving approaches to Encounter data collection, quality, and analysis
- Supports:
  - Analysis of Utilization patterns and variation
  - Generation of process/procedural Quality measures
  - Payer and Provider-level Utilization and Quality comparisons
- Limitations of Encounter data are similar to Claims data, and:
  - Encounters are not reimbursement requests:
    - Allowed amounts are not relevant and therefore not provided
    - Some APCDs require that payers provide a FFS equivalent amount to support Cost analysis
  - Completeness:
    - Unlike under FFS, providers lack a financial incentive to report all services rendered
    - May not reflect all services provided due to incentives, carve outs, or capitation
    - Not generally adjudicated, difficult to verify data quality and completeness

“Core” Files Support Many HPD Use Cases

- Analysis and Reporting on:
  - Utilization and Cost (may be limited for Encounters)
  - Quality
  - Coverage and Access
  - Population and Public Health
  - California Health System Performance
- Support research, public health, and operations uses
- Contribute to custom analyses and reports to inform discussions of current and emerging health care policy issues
- Provide information to support data users including: policymakers, public purchasers, payers and purchasers, providers, researchers, and the public

Claims and Encounters – Implications for HPD

Approximately 70% of commercially insured Californians are covered by health plans that generate Encounter data

- Core Claims and Encounter data will support Utilization and Quality use cases
- Encounters do not typically include allowed amounts and will create challenges for Cost analysis and reporting

Questions for the Review Committee:

- Should the HPD require managed care plans with capitation arrangements to provide a FFS equivalent allowed amount in Encounter data submissions?
- Can the HPD support credible Cost analysis and reporting based on a combination of claims-based allowed amounts and FFS equivalents?

Data Collection for Alternative Payment Models

Alternative Payment Models (APM)

- Why Collect APM Data?
  - Non-FFS reimbursement models are increasingly prevalent, especially in CA
  - Information is necessary to support HPD use cases
  - Payments do not flow through claims processing systems

- APM Examples
  - Population-Based Payment/Capitation – comprehensive, condition specific, or integrated finance and delivery systems
  - Bundled/Episode-based payment
  - Performance Incentives/Penalties
  - Shared Savings/Risk

- APM Information supports Total Cost of Care Analysis

National Experience with APM Data Collection

- OR and MA require submission of payment information for services and infrastructure not reimbursed under FFS. CO and MD are pursuing similar requirements.
- Data collected includes:
  - Fixed Payments: Population-Based/Capitation, Bundled/Episode-based
  - Quality or Financial Performance Incentives: Performance Payments and/or Penalties, Shared Savings/Risk
- Use Cases Supported with APM Data:
  - Uptake of APMs: Measure and track the proportion of services reimbursed and the number of members covered under non-FFS payment
  - Cost and Utilization Implications of APMs: Compare cost and utilization of services under various APMs relative to FFS reimbursement
  - Cost Analysis and Reporting: Incomplete/misleading without information on APM reimbursement

APM Uses, Reporting, and Impact

- Massachusetts Health Policy Commission (HPC)
  - Used in reports on Annual Cost Trends and Total Health Care Expenditures
  - Tracks performance against 3.6% annual growth benchmark
  - If the benchmark is exceeded, HPC may require high-growth payers or providers to implement performance improvement plans
  - Prescription Drug and Hospital Outpatient spending were the most significant drivers in 2016
- Oregon Health Authority (OHA)
  - Used in report on the percent of total medical spending (TMS) allocated to primary care
  - In 2015, commercial payers spent 9% of TMS on primary care; Medicaid CCOs spent nearly 13%
  - Significant variation across both payers and health plans
  - Results inform recommendations for “optimizing investment in primary care”
- See Appendix for details of APM data collection in each state

One Model for "Total" Cost of Care Reporting

- NRHI Total Cost of Care (TCoC) Project
  - Implement the HealthPartners™ TCoC methodology across multiple states to facilitate meaningful cost and utilization comparisons
  - Aggregated FFS claims data supplied by six APCDs
  - Funded by the Robert Wood Johnson Foundation (2013-2018)
- Based on total allowed amounts; does not capture value of encounters or alternative, value based payments
- Demonstrated application of standardized measurement specifications and production of meaningful cross-state comparisons
  - Three annual multi-state comparison reports published
  - Detailed cost and utilization reports distributed directly to primary care practices
- Primary care practices and policymakers can identify specific opportunities to lower costs and improve quality of care and population health
- Integrated Healthcare Association (IHA) of CA has adopted the HealthPartners™ methodology for their ongoing TCoC measurement and reporting

Other Non-Claims Data Sources

Pharmacy Rebate File

- Since 2017, MA has collected aggregated information on rebates paid by drug makers or PBMs. Colorado is implementing similar data submission requirements
- What are Pharmacy Rebates? After-the-fact drug manufacturer payments to Payers and PBMs to encourage formulary inclusion and ensure favorable out-of-pocket costs (e.g., preferred “tier” placement)
- Uses Cases Supported by a Pharmacy Rebate File:
  - In MA, Rx spending was identified as a major component of TCHE (over 18% of commercial spend in 2015/16). The annual HPC report includes information on high volume/cost drugs and conditions they are used to treat
  - Develop a more complete understanding of Total Health Care Spending: Little is known about the magnitude or impact of drug rebates
  - More accurate cross-payer comparisons: Pharmacy spending comparisons by payer will be misleading if based on payment information from claims alone

Rebates: Percentage of Total Rx Spend by Payer

Source	Data Analyzed	Medicare Part D	Medicaid	Private Insurance
Roehrig[1]	2016	22%	51%	12%
MA/CHIA[2]	2017	17.9%	51.7 % - MCO 52.7% - FFS	12.4%

1. Charles Roerhig, PhD, "The Impact of Prescription Drug Rebates on Health Plans and Consumers," Altarum, April 2018. Available online at: https://altarum.org/sites/default/files/Altarum-Prescription-Drug-Rebate-Report_April-2018.pdf
2. Center for Health Information and Analysis (CHIA), "Performance of the Massachusetts Health Care System, Annual Report, September 2018. Available online at: http://www.chiamass.gov/assets/2018-annual-report/2018-Annual-Report.pdf

Premium File

- Three APCD's (MA, NH and OR) collect aggregate information on the total monthly premiums collected for each insurance product/plan type, as well as the number of members covered. MA requests member counts parsed by age group, gender, and zip code
- Data are typically collected as a supplemental file
- Total Monthly Premium Amount is a required field in the Eligibility file of the "APCD-CDL™"
- Uses Cases Supported by the Premium File:
  - Premium Rate Review: Review of premium trends for specific health insurance market segments and plan types
  - More complete understanding of Total Health Care Spending

Premium Data Collection in MA, NH and OR

	Massachusetts	New Hampshire	Oregon
What is Collected?	Subscriber and Total Monthly Premium for Large Group Plans	Monthly Premium (or Equivalent) for Carriers and TPAs	Total Subscriber Monthly Premium for Fully-insured and Medicare Advantage plans and PBMs
Report/ Use Case	Track and report on changes in premiums, member cost sharing, benefit levels, and benefit design	Validation of Annual Hearings reports on Medical Loss Ratios and Premium Rate Filings. Assess trends in health care costs relative to premium rate increases	Network Adequacy Analysis and Calculation of Medical Loss Ratios

All three states collect Premium Data separate from the “Core” files.

Freedman HEALTHCARE

Questions?

Freedman HEALTHCARE

Appendix

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APM File

Comparison of the Two States that Collect APM Files

	Massachusetts	Oregon
Lines of Business Reported	Medicare, Medicare Advantage Medicaid Commercial Dual Eligibles	Medicare Advantage Medicaid MCO Commercial State Employees/Educators
Reporting Methodology	Payments by Provider/Group that Received Payment Payments by Zip Code of Member (requires attributing all payments to members)	Payments by Provider/Group that Received Payment Payments by Provider/Group that bore the risk for the members for whom the payment was made (OPTIONAL)
Payment Models Collected	"Homegrown" categories have evolved over time*	HCP-LAN Categories with a few additions
Payments with Multiple Components	Hierarchy for what payment arrangement category to assign the entire payment to	Requires all payments to be parsed out by type
Captures link to quality?	No±	Yes – HCP-LAN categories capture this
File Format	Excel. Different from other APCD data files	Flat File, Tab-Delimited. Same as APCD data
Authority to Collect Data	Separate law – total medical expenditure collection	APCD Enabling Statute
Submission Frequency and Deadline	Annual File Collected 5/17 for previous year (prelim) and than again following year (final)	Annual File Collected 9/30 for previous year

* Global budget (full benefits), global budget (partial benefits), limited budget, bundled payment, other non FFS, FFS
± MA recently (3/25/19)combined their APM file with their TME file. Previously, they collected information on whether the payment was tied to financial performance measures, quality performance measures , or both. They no longer do.

BREAK

Healthcare Payments Data Use Cases

April Review Committee Meeting

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Objectives for Session

- Share work to date on framework for use cases and specific examples, and obtain feedback
- Surface design questions and challenges, and enlist Review Committee members in addressing
- Reach agreement on framework as directionally correct, adjust course as needed

For Today: Use Case Framework and Examples

- Use Case Framework
  - Topic Categories – based on scan of existing APCD use cases and AB 1810 language
  - Audiences – priority is enabling data-driven policy decisions
  - Tiers –based on approach taken in Colorado, Tennessee and Oregon
- Use Case Examples
  - Examples and ideas galore!
  - Submissions from Review Committee
  - Selection criteria ➔ three examples for discussion

Topics

Cost and Utilization	Quality	Coverage and Access	Population and Public Health	Health System Performance
• Utilization and Spending • Price transparency • Price variation among providers • Total cost of care • Benchmarking • Cost-effectiveness • Low-value care • Cost of avoidable complications • Pharmaceutical cost, utilization • Oral health cost, utilization • Behavioral health cost, utilization	• Preventive screenings, immunizations - variation and comparison • Continuity of care (transitions in care setting, coverage) • Readmissions, hospital-acquired infection, preventable hospitalization • Preventable Emergency Department (ED) visits	• Coverage trends over time and geography • Access to care, including specialty care, dental, and behavioral health • Patient cost-sharing • Rate review/ rate-setting • Insurance coverage • Network adequacy • Premiums	• Chronic conditions (e.g., diabetes, asthma) prevalence, cost, quality • Opioid prescribing • Firearm injuries, incidence and cost • Connection between environment and chronic conditions (e.g., air quality and asthma) • Epidemiology: trends in cancers, infectious diseases, behavioral health conditions	• Effects of delivery system consolidation on cost, quality, access, equity • Evaluation of new models of care and payment • Integration of physical and behavioral health care • Care coordination for special populations, e.g. dual eligibles • Prevalence/ trends in alternative payment models

Audiences

Policymakers

- Legislators
- CA Health and Human Services Agency
- Regulators (DMHC, CDI)
- CA Department of Public Health and local public health departments
- Advocacy Organizations

Public Purchasers

- Department of Health Care Services ((Medi-Cal)
- Covered CA
- CA Public Employees Retirement System (CalPERS)

Payers and Purchasers

- Health plans
- Trusts and Labor Organizations
- Pharmacy benefit managers
- Employers
- Self-insured counties
- Benefits consultants

Providers

- Medical Groups and Independent Practice Associations (IPAs)
- Hospitals and Systems
- Community Health Centers
- Other health professional groups

Researchers

- Universities and think tanks
- Pharmaceutical companies and device manufacturers
- Data firms developing tools
- Policy and advocacy organizations

Public

- Consumers
- Patients and Families
- Media

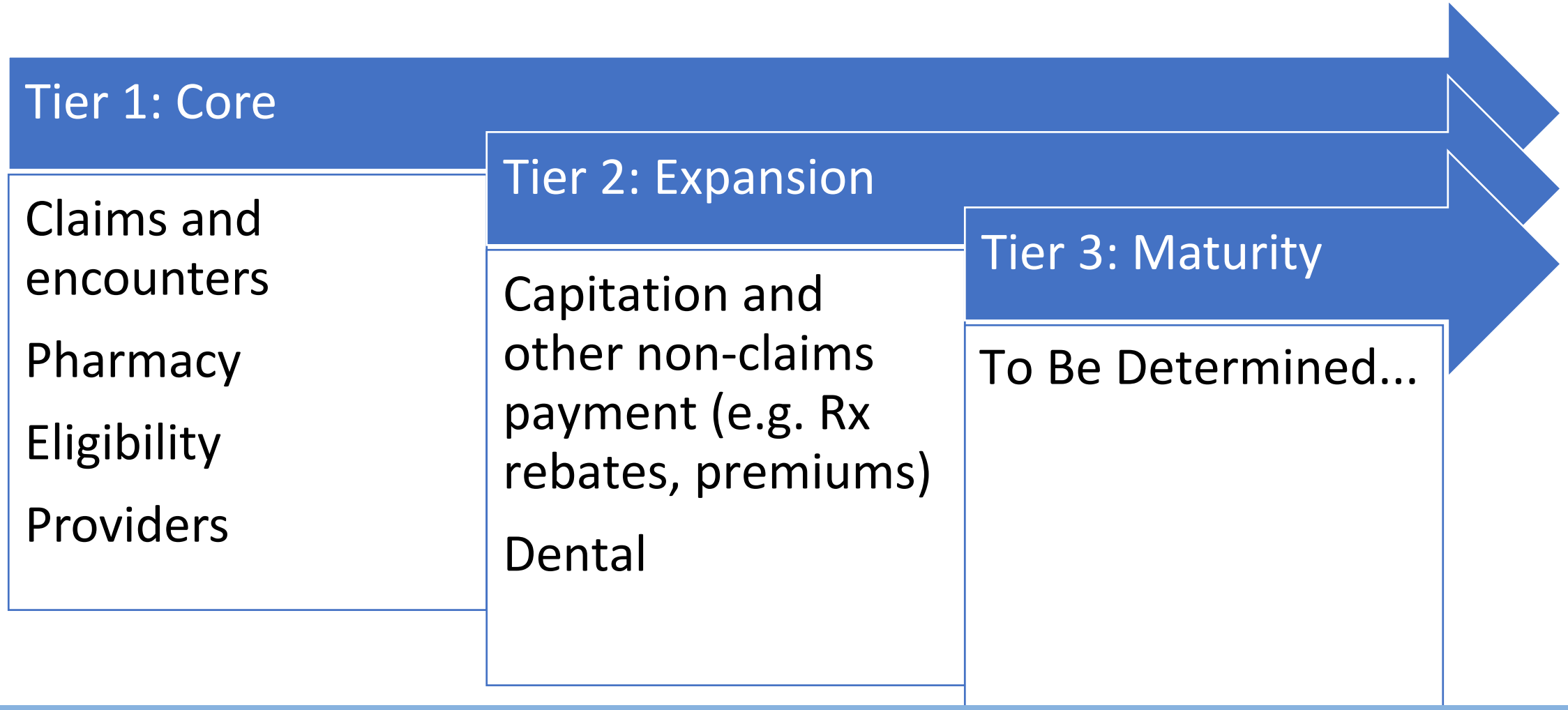
Data and Reporting “Tiers”

- Approach taken by Tennessee, Oregon, Colorado
- Themes of the “tier” approach:
  - Start with “core” data, straightforward analytics, relatively simple data products, noncontroversial outputs
  - Focus on practical, value-add results and data products in the short-term
  - Concurrently, pursue additional data sources and linkages that are more complex and challenging but enable additional use cases
  - Build confidence in the data and trust among stakeholders over time
  - Focus on transparency of process and outputs
  - Balance benefit of data collection with reporting burden

Lessons Learned from Other State APCDs

- Begin data analysis and development of initial public reporting once payers have submitted at least 3 years of data
  - Allows for calculation of the initial measures over multiple years, and some trend analysis
- Essential steps prior to public release to ensure high-quality data and output and to build confidence in the data:
  - Generation of the initial measures
  - Careful examination of results by year, payer type, and submitter
  - Stakeholder and partner engagement with the results
- Successful execution of progressively more complex use cases over time supports continuous improvement of data quality

Data Tiers


Tier 1: Core
Claims and encounters
Pharmacy
Eligibility
Providers
Tier 2: Expansion
Capitation and other non-claims payment (e.g. Rx rebates, premiums)
Dental
Tier 3: Maturity
To Be Determined...

Linkage Tiers

Tier 1: Core

Census data elements:

- Race/ethnicity
- Income
- Housing

Tier 2: Expansion

OSHPD hospital data

Vital Statistics:

- Death records
- Birth records

Surveys (e.g. CHIS)

CA open data

Tier 3: Maturity

Registries:

- Immunizations
- Chronic disease
- Cancer

CURES (opioids)

Reporting Tiers

Tier 1: Core

Summary statistics (medical, pharmacy) :

By geography (statewide, regional, county)

By demographics (age, gender, race/ethnicity)

By payer (e.g. Medi-Cal, Medicare, commercial)

Tier 2: Expansion

By product (e.g. HMO, PPO, ACO)

Trends and Patterns

Dental summary statistics

Tier 3: Maturity

Patterns of care or coverage at the individual level over time

Episodes of care

Longitudinal analyses (e.g. cost in last 6 months of life)

Discussion Topics

- Does the tiered approach resonate?
- For each of the major components (data, linkages, reporting):
  - Are the elements in the right tier?
  - What needs to be shifted?
  - What's missing?

- Importance and challenges of non-claims data in California

- Opportunity to leverage OSHPD's existing data and capabilities
  - Linking record level data

Review Committee Submissions

Review Committee Use Case Submissions

- 45 separate use cases submitted
- Themes
  - Assess value of care based on payment types (FFS versus Non-FFS)
  - Cost variations based on geography
  - Population health outcomes by geography, socioeconomics, and demographics
  - Site of care variations in cost and quality (e.g., Ambulatory Surgical Centers or Hospital Outpatient Departments)
  - Appropriateness of care

Review Committee Use Case Submissions

Use Case Topic	Number Submitted
Cost and Utilization	23
Quality	11
Coverage and Access	8
Population and Public Health	4
California Health System Performance	12

Review Committee Use Case Submissions

Audience	# of times listed as Primary
Policymakers	37
Public Purchasers	21
Payers and Purchasers	31
Providers	15
Researchers	9
Public	7

Use Case Examples

State APCD Examples Galore!

CIVHC Change Agent Gallery

Selection Criteria for Use Case Examples

- Interest to a various audiences
- Actionable: effective in other states with APCD
- Short-term value: feasible with “core + expansion” data
- Relevant to California landscape
- Priority for Review Committee members

Use Case Example #1

Use Case: Prevalence, Management, and Cost of Diabetes

Overview

Patterns of care for patients diagnosed with diabetes (or other chronic conditions)

Includes utilization, cost

By payer, product, geography

Tier 1 for prevalence (“core”)

Tier 2 for management and cost (“expansion”)

Tier 3 for episodes of care (“maturity”)

Audiences

Primary

- Policymakers
- Public Purchasers
- Payers and Purchasers

Secondary

- Providers
- Researchers
- Public

Outputs

Maps showing geographic variation, identify “hot spots” of high prevalence, low access/quality

Reports on trends over time and variation

Data on prevalence, cost on website and for download

Fact sheets, infographics, data stories

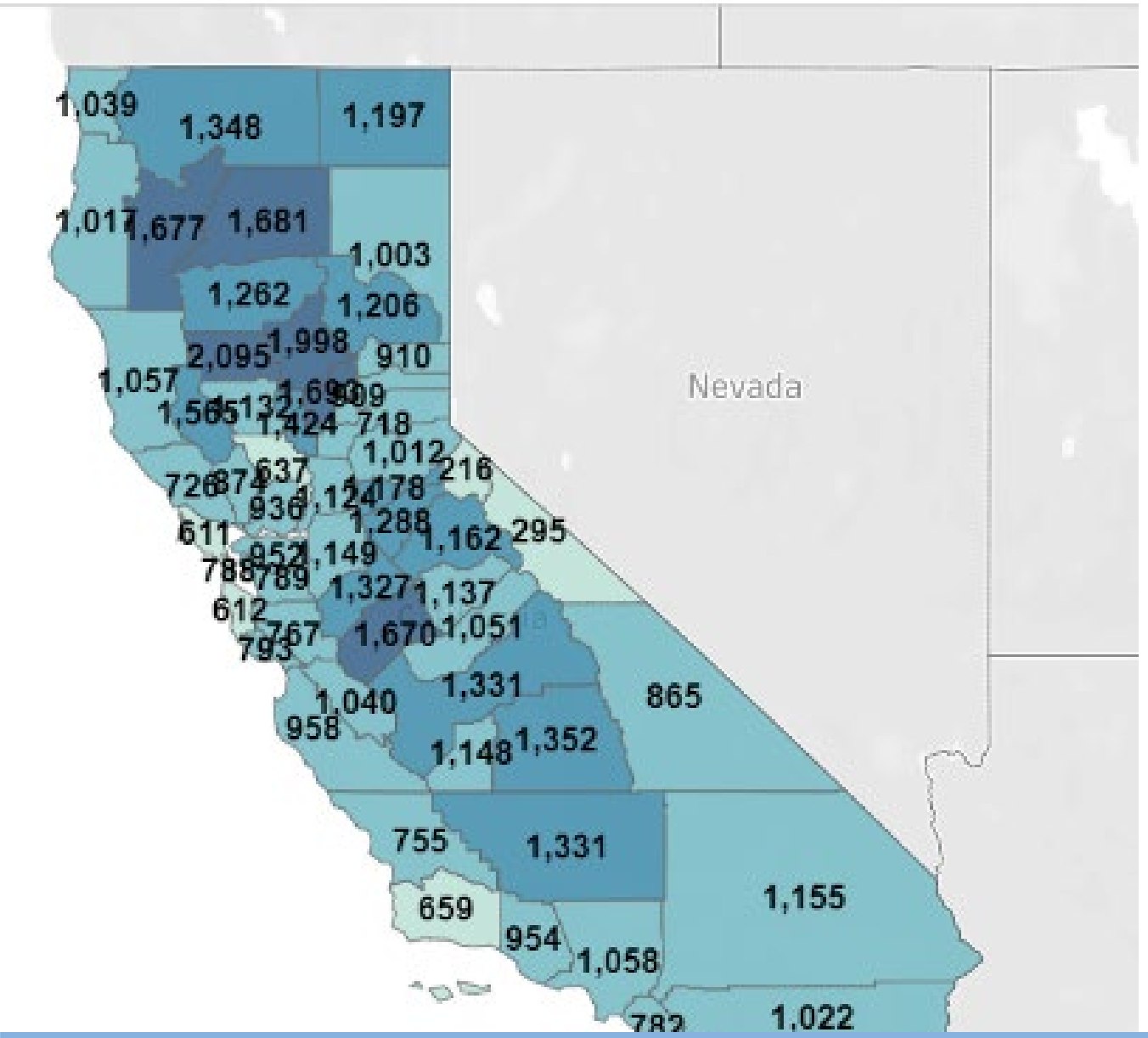
Value

Quantify cost of poor care, e.g. avoidable hospitalizations

Illuminate health disparities and develop targeted interventions

Benchmark network performance

Investigate association between prescription drug costs and health outcomes



Preventable Hospitalizations per 100,000 (2017)

This indicator provides the rates of preventable hospitalizations (per 100,000 population) for selected conditions. It is based upon a composite indicator for twelve ambulatory care-sensitive conditions. Examples include diabetes complications, adult asthma, hypertension, heart failure, dehydration, urinary tract infection, and bacterial pneumonia.

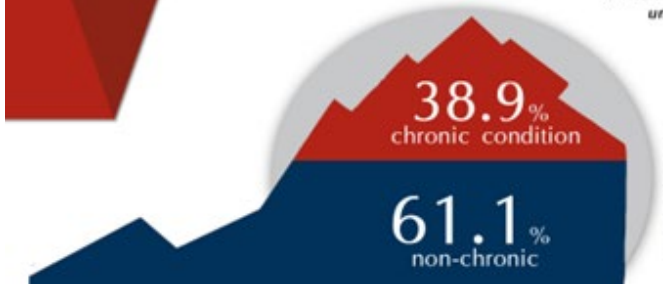
Source: Office of Statewide Health Planning and Development (CHHS Open Data)

Sources: Virginia Health Information, Center for Improving Value in Health Care

Chronic Conditions in Virginia

Chronic conditions - such as heart disease, cancer, stroke and type 2 diabetes - are common, costly and oftentimes preventable. According to the Centers for Disease Control and Prevention (CDC), chronic conditions are responsible for 7 of 10 deaths among Americans each year and account for 86% of the nation's healthcare costs.

*Overall analysis of chronic conditions for 2015 among commercially insured Virginia residents under the age of 65; all data provided by the Virginia All Payers Claim Database (APCD)



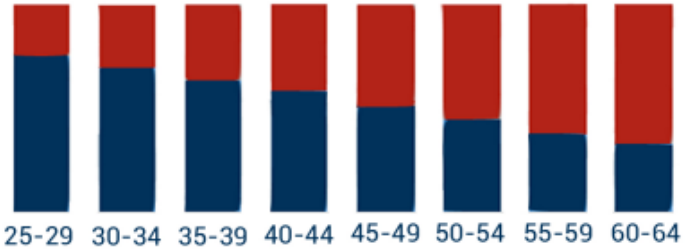
Among the roughly **3 million** Virginians with commercial claims in the Virginia APCD, **38.9%** had paid health insurance claims indicating the enrollee had a **chronic condition**.

Top Chronic Conditions in 2015*

1. Hypertension
2. Asthma
3. Diabetes w/o CAD
4. Chronic Musculoskeletal Disorders
5. Gastrointestinal Disorders

*Accounted for over 50% of individuals with a chronic condition.

Although chronic conditions affect people of all ages, the risk of chronic illness **increases with age**.



About half of the population had at least **one** chronic condition **by the age of 45**.

The average allowed amount*, or **dollars spent to directly pay for care**, for individuals who had a chronic condition was roughly **four times** the average allowed for individuals identified as non-chronic.

*displayed using standardized proxy reimbursement amount

Chronic Conditions in CO

CIVHC
CENTER FOR IMPROVING VALUE IN HEALTH CARE

Insights from the Colorado All Payer Claims Database interactive public reports @ www.civhc.org

Conditions Snapshot

Hypertension

12% of Coloradans were diagnosed with hypertension in 2015

Hypertension is the disease diagnosed most frequently among insured Coloradans

Hypertension is more prevalent in older age groups with marked differences between payer types

Hypertension Prevalence in Adults, 35-64

Medicaid	16.5%
Commercial	8.6%

Diabetes Type II

4.8% of Coloradans had a diabetes type II diagnosis in 2015

Diabetes type II is highest in the Medicare Advantage population

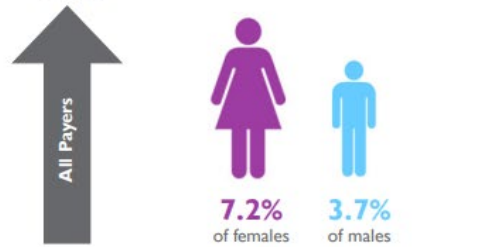
Diabetes Type II Rates, 2012-2015

Depression

5.1% of Coloradans had a depression diagnosis in 2015

Since 2012, depression has increased...

Depression is highest among mature adults, 35-64



Asthma

3.6% of Coloradans have asthma

Asthma rates have gone down across all payers since 2012

14.4%

Asthma is more prevalent in children with marked differences between payer types

Asthma Prevalence in Children, 0-17

Medicaid	6.03%
Commercial	3.96%

Use Case Example #2

Use Case: Primary Care Spending

Overview

Measure the proportion of health care spending that is allocated to primary care (providers, services, and settings)

Tier 2/Expansion for capitation, other non-claims primary care

Challenge to allocate capitation and other non-claims payment to primary vs. specialty

Audiences

Primary

- Policymakers
- Public Purchasers
- Payers and Purchasers

Secondary

- Providers
- Researchers
- Public

Outputs

Reports on trends over time and variation in primary care spend

Data on website and for download

Fact sheets, infographics, data stories

Maps showing geographic variation

Value

Benchmark primary care spending

Support research on how allocation of spending affects outcomes

Inform decisions about benefit and network design, public policy

Primary care spending: What's included?

To calculate percentage of total medical spending allocated to primary care, the sum of claims-based and non-claims-based payments to primary care providers is divided by the sum of total claims-based and non-claims-based payments to all providers (illustrated below). As the denominator, total payments include all payments for members including specialty care, mental health care, hospitalizations and more, but does not include prescription drugs.

$$\frac{\text{Claims-based payments for primary care} + \text{Non-claims-based payments for primary care}}{\text{Total claims-based payments} + \text{Total non-claims-based payments}} = \text{Percentage of medical spending allocated to primary care}$$

Claims-based payments

Payments to primary care providers and practices:

Primary care providers

- Physicians specializing in primary care, including family medicine, general medicine, obstetrics and gynecology, pediatrics, general psychiatry, and geriatric medicine
- Naturopathic and homeopathic providers
- Physicians' assistants
- Nurse practitioners

Primary care practices

- Primary care clinics
- Federally qualified health centers (FQHCs)
- Rural health centers

For primary care services:

- Office or home visits
- General medical exams
- Routine medical and child health exams
- Immunizations
- Preventive medicine evaluation or counseling
- Health risk assessments
- Routine obstetric care, including delivery
- Other preventive medicine

Non-claims-based payments

Payments to primary care providers and practices:

- Capitation payments and provider salaries
- Risk-based payments
- Payments for patient-centered primary care home or patient-centered medical home recognition
- Payments to reward achievement of quality or cost-savings goals
- Payments aimed at developing capacity to improve care for a defined population of patients, such as patients with chronic conditions
- Payments to help providers adopt health information technology, such as electronic health records
- Payments or expenses for supplemental staff or activities, such as practice coaches, patient educators, patient navigators or nurse care managers

Source: Primary Care Spending in Oregon: A Report to the Oregon State Legislature, February 2019

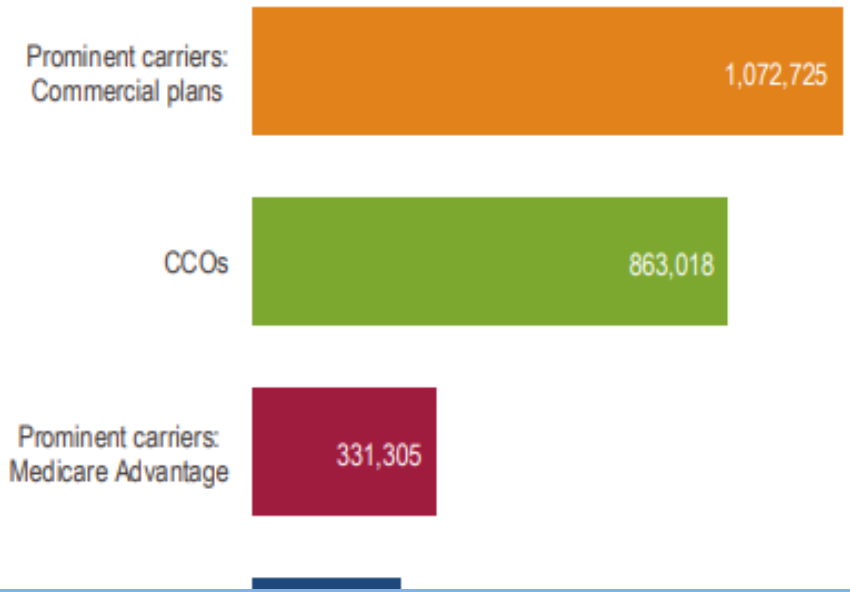
OSHPD
Office of Statewide Health Planning and Development

Enrollment and total primary care spending

The graphs on this page show enrollment and total primary care spending by prominent carriers and CCOs in calendar year 2017. Enrollment is reported as the average number of unique people enrolled in a given month. On the graph on the right are total primary care spending and total spending broken out by payer category.

Monthly enrollment

In any given month of 2017, an average of 863,018 Oregonians were enrolled in CCOs. In the same year, 1.7 million Oregonians were enrolled in commercial, Medicare Advantage, and PEBB and OEBB plans offered by prominent carriers.



Total primary care spending in 2017

Commercial plans, CCOs, Medicare Advantage plans, and PEBB and OEBB plans spent $1.5 billion on primary care out of $11.0 billion of total spending.

Commercial

Primary care spending
$558 million
Total spending
$4.2 billion
Percent primary care
13.4 percent

CCOs

Primary care spending
$433 million
Total spending
$2.6 billion
Percent primary care
16.5 percent

Medicare Advantage

Primary care spending
$295 million
Total spending

PEBB and OEBB

Primary care spending
$137 million
Total spending

Source: Primary Care Spending in Oregon: A Report to the Oregon State Legislature, February 2019

Use Case Example #3

Use Case: Prescription Drug Spending

Overview

Bring together prescription drug utilization and spending data from pharmacies with data from medical settings such as physician offices and hospitals to create a complete picture of prescription drug spending in the state. Complement information available through SB 17.

Tier 1/Core

Audiences

Primary

- Policymakers
- Public Purchasers
- Payers and Purchasers

Secondary

- Providers
- Researchers
- Public

Outputs

Reports on conditions associated with prescription drug spend, trends over time

Analysis of prescription drug costs by payer, therapeutic category, care setting

Maps showing geographic variation

Data on website and for download

Issue briefs, fact sheets

Value

Identify and address cost drivers

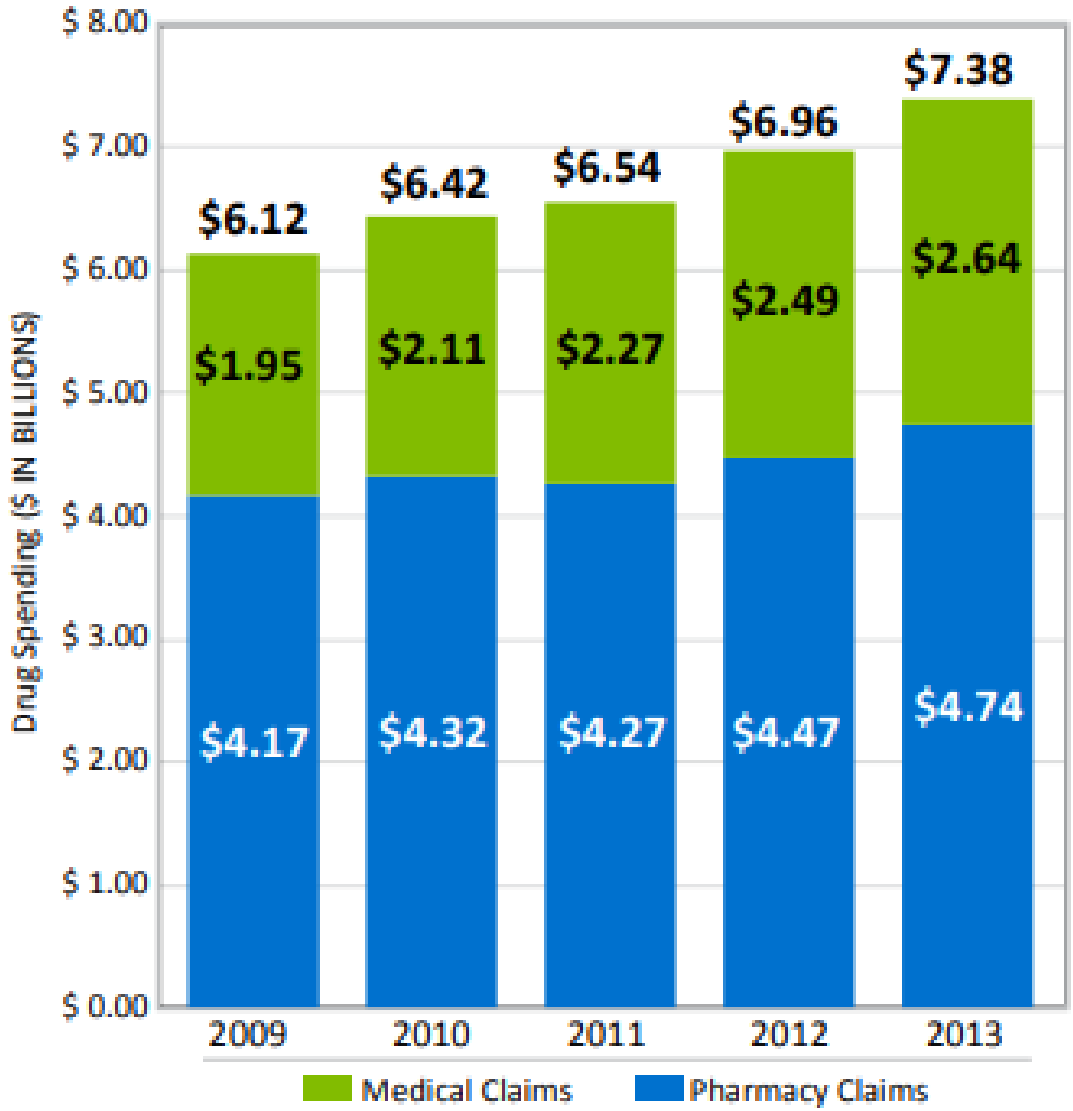
Benchmark prescription drug costs

Monitor out of pocket costs for prescription drugs, and investigate how costs affect outcomes

Develop purchasing strategies that narrow variation and reduce prices

MN APCD
All Payer Claims Database

Figure 1:
Prescription Drug Spending in Minnesota by Claim Type



Source: Pharmaceutical Spending and Use in Minnesota: 2009-2013

Key Findings

- Spending in 2013 on all prescription drugs for Minnesotans with insurance coverage captured in the MN APCD was about $7.4 billion.
- Prescription drugs spending in pharmacy and medical claims accounted for approximately 20 percent of total health care consumption that year.
- Between 2009 and 2013, prescription drug spending rose 20.6 percent, with medical claims accounting for more than one-half (55.1 percent) of this growth.
- The greater role of medical claims in drug spending, relative to pharmacy claims, is due to higher cost-per-claim (more than 200 percent) and faster year-over-year growth (23.5 percentage points between 2009 and 2013).
- Across the five-year study period, Minnesotans with insurance coverage had, on average, 12 pharmacy claims and 3 medical claims per year for prescription drugs.

OSHPD
Office of Statewide Health Planning and Development

Recap Session Objectives

- Share work to date on framework for use cases and specific examples, and obtain feedback
- Surface design questions and challenges, and enlist Review Committee members in addressing
- **Reach agreement on framework as directionally correct, adjust course as needed**

Public Comment

Upcoming Review Committee Meeting : May 16, 2019