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
<table>
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<tr>
<th>Item</th>
<th>Descriptions</th>
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</table>
| 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,
OSHPD
Follow Up from March 21 Meeting
# Updated Healthcare Payments Data Program Review Committee Meeting Topics

<table>
<thead>
<tr>
<th>March</th>
<th>April</th>
<th>May</th>
<th>June</th>
<th>July</th>
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<tbody>
<tr>
<td><strong>Kickoff</strong></td>
<td><strong>Data Types and Use Cases</strong></td>
<td><strong>Data Collection</strong></td>
<td><strong>Enhancing Database Analytics</strong></td>
<td><strong>Data Submitters</strong></td>
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</table>
| • Welcome & Introductions  
• Background on APCDs  
• Goals for the Committee | • Types of Data in the System  
• Claims Data 101  
• Use Case Categories  
• Cost & Utilization  
• Quality  
• Coverage & Access  
• Population Health  
• System Performance | • Data collection format options  
• Streams of data collection (Medicare, Medicaid, Commercial)  
• Data collection considerations in California’s complex managed care environment | • What other relevant data sets can be linked to the HPD data system.  
• Opportunities for additional enhancements to the database | • 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

Data Quality
• Roles and responsibilities in ensuring data quality throughout its lifecycle
• Effective collaborations with submitters to ensure data quality
• Documentation processes for data quality

September

Data Governance and Privacy
• California privacy landscape
• Privacy considerations for data collection, use and dissemination

October

Technology Alternatives
• 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

November

Governance: Administrative Plan for Operating the Database
• Considerations for effectively governing a data management system
• Opportunities to leverage existing data governance structures

December

Sustainability
• 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

Presentation to the HPD Review Committee
April 18, 2019
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

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<thead>
<tr>
<th>Category</th>
<th>Commercial Payers</th>
<th>Medicaid Programs</th>
<th>Medicare FFS</th>
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</table>
| **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**       | 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)
Charges vs. Allowed vs. Paid Amounts

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<thead>
<tr>
<th>CHARGE</th>
<th>INSURANCE DISCOUNT</th>
<th>ALLOWED AMOUNT</th>
<th>COPAY (fixed)</th>
<th>COINSURANCE (%)</th>
<th>DEDUCTIBLE</th>
<th>INSURANCE PAYMENT</th>
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<td>$ 225</td>
<td>$ 275</td>
<td>$ 25</td>
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Largely Irrelevant

Usually What We Want to Know

Patient Responsibility

What the Payer Paid

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
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

<table>
<thead>
<tr>
<th>Source</th>
<th>Data Analyzed</th>
<th>Medicare Part D</th>
<th>Medicaid</th>
<th>Private Insurance</th>
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<tbody>
<tr>
<td>Roehrig¹</td>
<td>2016</td>
<td>22%</td>
<td>51%</td>
<td>12%</td>
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<tr>
<td>MA/CHIA²</td>
<td>2017</td>
<td>17.9%</td>
<td>51.7% - MCO</td>
<td>52.7% - FFS</td>
</tr>
</tbody>
</table>


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

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<thead>
<tr>
<th>Massachusetts</th>
<th>New Hampshire</th>
<th>Oregon</th>
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<tbody>
<tr>
<td>What is Collected?</td>
<td>Subscriber and Total Monthly Premium for Large Group Plans</td>
<td>Monthly Premium (or Equivalent) for Carriers and TPAs</td>
</tr>
<tr>
<td>Report/Use Case</td>
<td>Track and report on changes in premiums, member cost sharing, benefit levels, and benefit design</td>
<td>Validation of Annual Hearings reports on Medical Loss Ratios and Premium Rate Filings. Assess trends in health care costs relative to premium rate increases</td>
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</table>

All three states collect Premium Data separate from the “Core” files.
Questions?
Appendix
### Comparison of the Two States that Collect APM Files

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<thead>
<tr>
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<th>Massachusetts</th>
<th>Oregon</th>
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</table>
| **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
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
<table>
<thead>
<tr>
<th>Topics</th>
<th>Cost and Utilization</th>
<th>Quality</th>
<th>Coverage and Access</th>
<th>Population and Public Health</th>
<th>Health System Performance</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>• Utilization and Spending</td>
<td>• Preventive screenings, immunizations - variation and comparison</td>
<td>• Coverage trends over time and geography</td>
<td>• Chronic conditions (e.g., diabetes, asthma) prevalence, cost, quality</td>
<td>• Effects of delivery system consolidation on cost, quality, access, equity</td>
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<td></td>
<td>• Price transparency</td>
<td>• Continuity of care (transitions in care setting, coverage)</td>
<td>• Access to care, including specialty care, dental, and behavioral health</td>
<td>• Opioid prescribing</td>
<td>• Evaluation of new models of care and payment</td>
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<td></td>
<td>• Price variation among providers</td>
<td>• Readmissions, hospital-acquired infection, preventable hospitalization</td>
<td>• Patient cost-sharing</td>
<td>• Firearm injuries, incidence and cost</td>
<td>• Integration of physical and behavioral health care</td>
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<tr>
<td></td>
<td>• Total cost of care</td>
<td>• Preventable Emergency Department (ED) visits</td>
<td>• Rate review/ rate-setting</td>
<td>• Connection between environment and chronic conditions (e.g., air quality and asthma)</td>
<td>• Care coordination for special populations, e.g. dual eligibles</td>
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<tr>
<td></td>
<td>• Benchmarking</td>
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<td>• Insurance coverage</td>
<td>• Epidemiology: trends in cancers, infectious diseases, behavioral health conditions</td>
<td>• Prevalence/ trends in alternative payment models</td>
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<tr>
<td></td>
<td>• Cost-effectiveness</td>
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<td>• Network adequacy</td>
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<td>Audiences</td>
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<td><strong>Policymakers</strong></td>
<td>• Legislators</td>
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<td>• CA Health and Human Services Agency</td>
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<td>• Regulators (DMHC, CDI)</td>
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<td>• CA Department of Public Health and local public health departments</td>
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<td>• Advocacy Organizations</td>
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<td><strong>Public Purchasers</strong></td>
<td>• Department of Health Care Services ((Medi-Cal))</td>
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<td>• Covered CA</td>
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<td>• CA Public Employees Retirement System (CalPERS)</td>
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<td><strong>Payers and Purchasers</strong></td>
<td>• Health plans</td>
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<td>• Trusts and Labor Organizations</td>
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<td>• Pharmacy benefit managers</td>
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<td>• Employers</td>
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<td>• Self-insured counties</td>
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<td>• Benefits consultants</td>
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<td><strong>Providers</strong></td>
<td>• Medical Groups and Independent Practice Associations (IPAs)</td>
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<td>• Hospitals and Systems</td>
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<td>• Community Health Centers</td>
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<td>• Other health professional groups</td>
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<td><strong>Researchers</strong></td>
<td>• Universities and think tanks</td>
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<td></td>
<td>• Pharmaceutical companies and device manufacturers</td>
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<td>• Data firms developing tools</td>
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<td>• Policy and advocacy organizations</td>
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<td><strong>Public</strong></td>
<td>• Consumers</td>
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<td>• Patients and Families</td>
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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

<table>
<thead>
<tr>
<th>Use Case Topic</th>
<th>Number Submitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost and Utilization</td>
<td>23</td>
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<tr>
<td>Quality</td>
<td>11</td>
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<tr>
<td>Coverage and Access</td>
<td>8</td>
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<tr>
<td>Population and Public Health</td>
<td>4</td>
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<tr>
<td>California Health System Performance</td>
<td>12</td>
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## Review Committee Use Case Submissions

<table>
<thead>
<tr>
<th>Audience</th>
<th># of times listed as Primary</th>
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<tbody>
<tr>
<td>Policymakers</td>
<td>37</td>
</tr>
<tr>
<td>Public Purchasers</td>
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<tr>
<td>Payers and Purchasers</td>
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<tr>
<td>Providers</td>
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</tr>
<tr>
<td>Researchers</td>
<td>9</td>
</tr>
<tr>
<td>Public</td>
<td>7</td>
</tr>
</tbody>
</table>
Use Case Examples
State APCD Examples Galore!

The ABCs of APCDs: How States Are Using Claims Data to Understand and Improve Care

APCD Showcase: States Leading by Example

Welcome to the APCD Showcase where examples from state all-payer claim databases (APCDs) have been organized in order to provide stakeholders with tangible examples of APCD reports and websites. The examples have been organized by intended audience, and are also searchable by additional criteria. We invite you to explore the site and learn more about the value that APCDs provide to states and their stakeholders.
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)
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 85% of the nation’s healthcare costs.

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

Sources: Virginia Health Information, Center for Improving Value in Health Care
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 the 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
- For primary care services:
  - Office or home visits
  - General medical exams
  - Routine medical and child health exams
  - Immunizations

**Non-claims-based payments**
- Payments to primary care providers and practices:
  - Primary care practices: Federally qualified health centers (FQHCs), Rural health centers
  - 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-saving 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

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.

<table>
<thead>
<tr>
<th>Payer Category</th>
<th>Primary Care Spending</th>
<th>Total Spending</th>
<th>Percent Primary Care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Commercial</strong></td>
<td>$558 million</td>
<td>$4.2 billion</td>
<td>13.4 percent</td>
</tr>
<tr>
<td><strong>CCOs</strong></td>
<td>$433 million</td>
<td>$2.6 billion</td>
<td>16.5 percent</td>
</tr>
<tr>
<td><strong>Medicare Advantage</strong></td>
<td>$295 million</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>PEBB and OEBB</strong></td>
<td>$137 million</td>
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</tbody>
</table>

Source:
Primary Care Spending in Oregon: A Report to the Oregon State Legislature, February 2019
Use Case Example #3
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
Figure 1: Prescription Drug Spending in Minnesota by Claim Type

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.

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