

**ESTABLISHING A PLAN FOR STANDARDIZING
ALL-PAYER CLAIMS DATA COLLECTION
MEETING MINUTES
MAY 6, 2009**

**NATIONAL ASSOCIATION OF HEALTH DATA ORGANIZATIONS
REGIONAL ALL-PAYER HEALTH INFORMATION COUNCIL**

Funding provided by Agency for Healthcare Research and Quality

PARTICIPANTS

Al Prysunka, Maine Health Data Organization, Regional All Payer Healthcare Information Council, National Association of Health Data Organizations

Amy Costello, Regional All Payer Healthcare Information Council, Institute for Health Policy and Practice, University of New Hampshire

Anne Elixhauser, Agency for Healthcare Research and Quality

Aparna Higgins, America's Health Insurance Plans

Arika Pierce, Health Management Systems

Bob Davis, National Association of Health Data Organizations

Carmella Bocchino, America's Health Insurance Plans

Cynthia Wark, America's Health Insurance Plans

Denise Love, National Association of Health Data Organizations

Doris Lotz, Medicaid Medicaid Directors Learning Network

Ed McDonough, Harvard Pilgrim Health Care

Irene Fraser, Agency for Healthcare Research and Quality

Jason Martiesian, United Health Care

Jeff Gabardi, America's Health Insurance Plans

Jeff Tindall, Cigna

Jim Harrison, Maine Health Information Center

Jo Porter, Regional All Payer Healthcare Information Council, Institute for Health Policy and Practice, University of New Hampshire

Jon Harvell, Maine Health Information Center

Josh Goldberg, National Association of Insurance Commissioners

Karen Milgate, Centers for Medicare & Medicaid Services

Katherine Pelletreau, Maine Association of Health Plans

Kathie Kendrick, Agency for Healthcare Research and Quality

Kathleen Nolan, National Governors Association

Kory Mertz, National Conference of State Legislatures

Lisa Talley-Marchese, United Health Care

Lisa Tourville, Humana

Mary Taylor, Aetna

Patrick Miller, Regional All Payer Healthcare Information Council, Institute for Health Policy and Practice, University of New Hampshire

Paul Barringer, United Health Care

Ranyan Lu, United Health Care

Shannon Robshaw, Louisiana Health Care Quality Forum

Tom Granatir, Humana

EXECUTIVE SUMMARY

With funding from the Agency for Healthcare Research and Quality, members from the National Association of Health Data Organizations (NAHDO) and the Regional All-Payer Health Information Council (RAPHIC) convened a group of stakeholders to:

- 1) provide an overview of the current status of development of APCDs among the states,
- 2) highlight the value and many applications of claims data,
- 3) present emerging issues with non-standard collection of claims data, and
- 4) discuss potential solutions for standardizing claims data collection.

APCD OVERVIEW

APCDs can be used to answer research and policy questions such as: determining health care utilization patterns and rates; identifying gaps in disease prevention and health promotion services; evaluating access to care; assisting with benefit design and planning; analyzing statewide and local health care expenditures by provider, employer and geography; and establishing clinical guidelines related to quality, safety, and continuity of care.

APCDs typically include quite detailed data derived from medical, eligibility, provider, pharmacy, and/or dental data files from payers, either private insurance companies or public payers. Currently, 19 states are in some stage of developing an APCD: six states have existing systems, two are in development, and 11 have expressed strong interest. APCDs are typically composed of several common types of health care claims data from the major payers. To date, the sources of data that have typically been incorporated into APCDs include eligibility, provider, private or commercial claims data (medical, dental, and pharmacy), Medicaid, and Medicare claims data. There is the potential to include other sources, such as federal employees, workers' compensation, and uninsured data. The data is submitted by the carriers, third party administrators (TPA), and pharmacy benefits managers (PBM) to the APCDs. Which data elements are submitted and the format for those data elements (or fields of the claim) are largely determined by the administrative or legislative rules governing data collection for the APCD.

APCDs typically include data elements that identify the patient (encrypted SSN)ⁱ, the type of product (HMO, POS, etc), type of contract (single, family), demographics (gender, residence), diagnosis codes (including e-codes), procedure codes (ICD, CPT), revenue codes, services dates, service provider (and id), prescribing physician, plan payments, member payment responsibility (co-pay), date paid, type of bill, and facility type. Information that is typically excluded: services provided to uninsured (with a few exceptions), denied claims, workers' compensation claims, premium information, capitation fees, administrative fees, back-end settlement amounts, referrals, test results from lab work, results from imaging, provider affiliation with group practice, and provider network information.

VALUE OF APCDS

APCDs are being built and used around the country (particularly in the Northeast) for public health purposes, as well as health services and public policy research. In New Hampshire, claims data have been used to better understand the distribution of health insurance coverage; the Office of Medicaid Business and Policy in New Hampshire Department of Health and Human Services calculated the percentage of people covered by commercial

insurance or Medicaid by health service area. Maine recently released a HealthCost website (<http://www.healthweb.maine.gov/claims/healthcost/default.aspx>), building on the analysis methodology developed in New Hampshire, and based on all payer claims data for Maine residents (including Medicare claims). The New Hampshire Purchasers Group on Health, a coalition of large public employers in New Hampshire, is using claims data to more closely examine their healthcare costs pricing across providers by three different payers. With funding from the Center for Disease Control and Prevention Assessment Initiative, the New Hampshire Institute for Health Policy and Practice is augmenting the health web query system for the state with the addition of a claims data-based web query module (in development) that produces estimates for the number of claims with a particular condition or disease for a user-defined geographic area.

However, there are some issues with the future development of state-based APCDs related to the lack of a standard protocol for APCDs implementation; there is no clear path for development of APCDs and no “right” way for every state (states have varying arrangements of governance and legislative authority). It is also expensive for states to figure out how to start an APCD without guidance about legislation and administrative rules development. In addition, the development of an APCD may begin with a non-state entity.

Current issues and challenges with APCD data itself include: receiving data feeds from multiple insurers; cross-walking insurer processing rules; no two insurers are alike and what is needed to pay a claim and what they keep varies from payer to payer; linking pharmacy carve-outs to medical claims when the member identifiers are not consistent from one data system to the other; and determining the right amount of clinical data to be included in the claims data. Inconsistency in collection standards, codes, and methodology across states yields lack of interstate/national comparability of data, as well as high costs for data submitters (multiple formats) and high costs for data recipients and processors. This can result in higher costs and challenges for those who analyze the data. While standardization cannot solve for all the problems and challenges with APCDs outlined above, there are implications for data collection, data release, meta rules development, and claims data-based tools development (like HCUP) associated with standardization.

The goal of standardization is to develop consistency in collection standards and codes, establish methodology to create interstate comparability in the data, and reduce costs for submission and release of data. Principally, there are resources to be saved for data submitters, data collectors, and data users.

One of the carriers in the meeting offered that all of us share this problem with non-standard data formats. “We have difficulty understanding what we are doing” AND managing the health of the population. Another carrier indicated that “she would like to second that”. Her organization has seen a 50% increase year over year for reports and extracts, and needed an increase in staff needs because each state has their own twist on the data extract that they require. She would like to limit the “human touch” required. It is not just a compliance issue, but also a way to make improvements to the data that the insurer would like to make.

As a result of the discussion, one carrier proposed a “wish list”: 1) have a seat at the table; 2) develop a standard for APCD claims data submission; 3) develop a mutually beneficial schedule for revisions to the standard; and 4) develop an IT release schedule to accommodate the resources required to update/revise the standard file format.

Aetna , Cigna, Humana, Harvard Pilgrim, Regence, and United agreed that this is urgent for their organizations. We need to engage stakeholders in areas of confluence.

PLANS FOR NEXT STEPS

1. Establish Working Group, starting with RAPHIC and move up to national level of conversation
 - a. Develop timeline, budget, and funding plan for developing an APCD data submission standard
 - b. Develop collection standards for files, fields, and codes
 - c. Identify process for implementing standards
 - d. Share findings and plan with Stakeholder group (today's participants and technical staff)
 - e. Develop business plan and vision for future
2. Stakeholder group
 - a. Review findings of working group
 - b. Maintain momentum for standardization

BACKGROUND

In April 2008, the first National All-Payer Claims Database Conference was held by the National Association of Health Data Organizations (NAHDO), the Regional All-Payer Health Information Council (RAPHIC), the Massachusetts Health Data Consortium, and the New Hampshire Institute for Health Policy and Practice (NHIHPP). The conference was attended by representatives from more than twenty states, federal agencies, universities, hospitals, health plans, and purchasers. The conference provided an opportunity for participants to learn more about the value of all payer claims databases (APCDs), share lessons learned in the development of APCDs, as well as begin the discussion of the next steps in development of APCDs, including the potential for standardization of the submission of data to APCDs.

In October of 2008, NAHDO hosted a follow up, one-day session at their annual conference that focused on APCD applications and next steps in APCD standards development.

It became apparent at both the April and October conferences that the interest among the states in APCDs is growing. This growth is organic, and there is no one method for creating an APCD or submitting data to one. The full definition of an APCD still needs consensus. Some states are exploring the idea of developing an APCD (Connecticut), others are drafting legislation (Tennessee and Oregon), and others are working together on a common template for data submission (Vermont, New Hampshire, Massachusetts and Maine); but there is no nationally accepted procedure or standard for doing so.

This increase in interest in APCDs over the last ten years is promising in terms of the potential for claims data to be used to greatly expand existing administrative data (such as hospital discharge data) for public health and health services research and public policy purposes on a regional (and possibly national) basis. However, with no national standard for data submission, each state is developing its own data submission rules, which will likely hamper the ability to develop multi-state or national databases. The state-based systems will also create undue burden for carriers that are required to submit data in different formats for each state. A uniform national standard would avert this impending "tsunami" by streamlining the data submission process to make it easier for researchers to use the data and for health plans and other payers to submit data.

Over the last year, the Agency for Healthcare Research and Quality (AHRQ) has been in conversation with both NAHDO and RAPHIC about a strategy for next steps to organize the growing interest in APCDs and engage stakeholders in a thoughtful strategy for averting the perfect storm of state-specific data submission rules. The three organizations agreed that coordination is imperative and hosted two meetings in the spring of 2009 to pool knowledge about the current status of APCDs and discuss a strategy for standardization of claims data. At the first

meeting in February 2009, representatives from NAHDO, RAPHIC, and AHRQ presented material that could be used for introducing the concept, value, and applications of APCDs to health plans and other stakeholders. Plans for a meeting with this “Stakeholder Group” were developed at the end of the meeting and over the course of a series of phone calls. The Stakeholder meeting was held at the Association of Health Insurance Plans (AHIP) in Washington, DC on May 6, 2009.

WELCOME

Kathleen Kendrick, Deputy Director of AHRQ, opened the meeting with appreciation to those in attendance. Kathleen reminded the group that we are all receiving data requests, and getting data requests in many different ways can be daunting. Being able to come together to talk about ways to address issues is the purpose of this meeting.

Patrick Miller of UNH-RAPHIC reiterated Kathleen Kendrick’s point and suggested that the intent of the meeting is to make the process easier for those receiving and transmitting data, potentially through a standardization process for claims data. He explained that the purpose of today’s meeting is to provide an understanding of:

- the evolution of APCDs;
- power of APCDs;
- the issues associated with the impending tsunami of additional APCDs and lack of standardization; and
- to discuss a proposed solution for action.

Patrick Miller noted that there are many types of users for claims data (e.g. payers, providers, Medicaid, government policy staff, consumers), and the value of the information has been demonstrated (he provided examples later in the presentation). There are challenges with standardization and we will need to find ways to support creation of national standards as applications, research, and logistics are all impacted by standardization issues. He described the clear benefit to the payers, especially the multi-state payers.

OVERVIEW – EVOLUTION OF APCDS

Denise Love, President of NAHDO, explained that APCDs supplement other data for health services and policy research. We have a complete picture of health care from Medicare, but it is limited to that population. We have a complete picture of care from Medicaid, but it is limited to that population. Hospital inpatient and outpatient (emergency department data) provide a complete picture of care for those services. The Medical Expenditure Panel Survey (and other surveys) provide a sample of office-based care but not population-based, and not a large enough sample for state estimates.

Denise Love explained that APCDs can be used to answer research and policy questions such as: determining health care utilization patterns and rates, identifying gaps in disease prevention and health promotion services; evaluating access to care; assisting with benefit design and planning; analyzing statewide and local health care expenditures by provider, employer, and geography; establishing clinical guidelines related to quality, safety, and continuity of care. Denise suggested that we can put the various kinds of data together but we still have gaps. Hospital discharge data has a pretty complete picture of inpatient care across most states, yet there is not a good picture of outpatient care. APCDs provide important data to supplement Medicare, Medicaid, hospital, and MEPS data. APCDs provide another window into the healthcare system to answer some of the important research and policy questions.

APCDs typically include quite detailed data derived from medical, eligibility, provider, pharmacy, and/or dental data files from payers, either private insurance companies or public payers. Currently, 19 states are in some stage of developing an APCD (Figure 1).

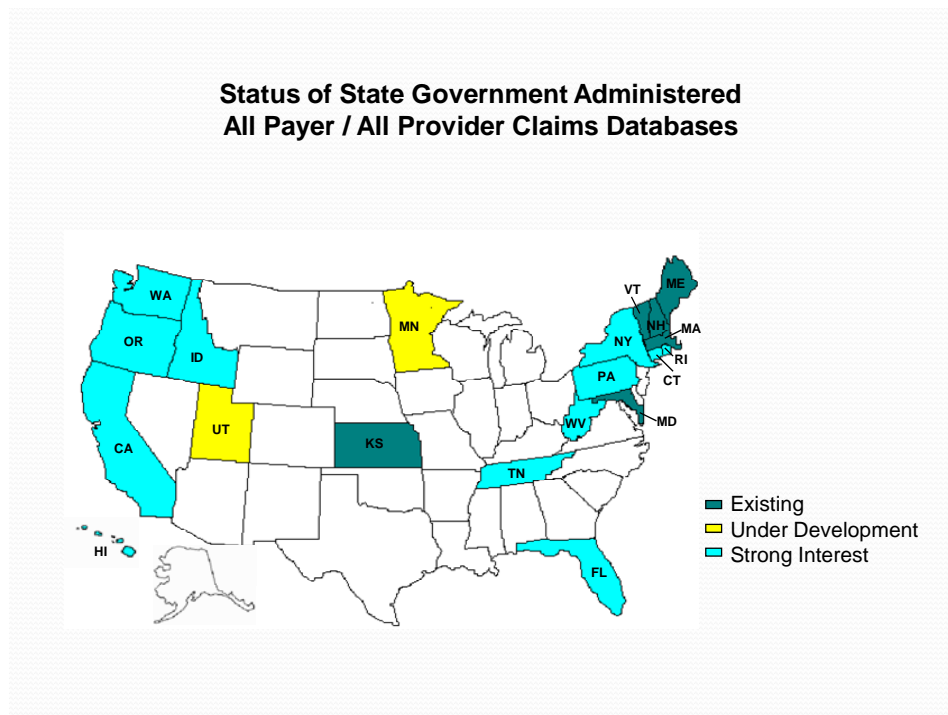


Figure 1. Status of State Government Administered All Payer/ All Provider Claims Databases

Al Prysunka, Executive Director of Maine Health Data Organization and board member of NAHDO, described the current status of APCDs development across the states. The Northeast states are creating systems, following the lead of Maine, which established an APCD in 2001. Al reported that many of the political and technical issues have been addressed in the Northeast, creating good regional coverage of claims data. Maryland has an APCD, but it is different from the APCDs of the Northeast. Kansas has some form of payment data, but it is a hybrid form. Utah's regulations for an APCD have not been passed but there is a lot of activity and interest in that state. Oregon has bills in the legislature and is waiting on ways and means for funding of an APCD. Al Prysunka and Denise Love have been contacted by many states that are still exploring the idea. Al also indicated that funding of APCDs is a factor but states are finding ways to do it.

Patrick Miller also noted that at the April 2008 conference in Beverly, there were 28 states represented and over 100 attendees. The APCD session at the NAHDO October 2008 conference had 100 people; the interest at the state level is real. Denise Love thanked AHRQ and Commonwealth for their support of both of those conferences and noted that there will be another all-day session at the NAHDO conference in October 2009.

In response to a question about the link between APCDs and health information exchange, Patrick Miller explained that this is an evolutionary process from HDDS to claims to clinical data; in the future, we can see the case for merging clinical data in with claims data. For example, the GE MQIC database contains national GE EMR customer data that could potentially be merged with administrative data.

APCDs are typically composed of several common types of health care claims data from the major payers. To date, the sources of data that have typically been incorporated into APCDs include eligibility, provider, private or commercial claims data (medical, dental, and pharmacy), Medicaid, and Medicare claims data. There is the potential to include other sources, such as federal employees, workers' compensation and uninsured claims data. The data is submitted by the carriers, third party administrators (TPA), and pharmacy benefits managers (PBM) to the APCDs. Which data elements are submitted and the format for those data elements, or fields of the claim, are largely determined by the administrative or Legislative rules governing data collection for the APCD in that state.

Al Prysunka described the similarities and variation among Massachusetts, Maine, New Hampshire, Minnesota and Vermont in terms of the types of payers represented in the APCDs. Of these five states, all collect commercial claims data. Only Maine collects Medicare data (Vermont is planning to collect in the future). Only Maine and Minnesota have Medicaid data fully integrated into the APCDs (New Hampshire collects it but does not have the data fully integrated). Of the five states, none are currently collecting comprehensive claims data on the uninsured, but New Hampshire has pending legislation which includes language about the collection of claims data about the uninsured, and Maine collects pseudo-claims for a small percentage of the uninsured population. Al Prysunka explained that the pseudo-claims for Maine are managed by an Anthem TPA that submits them to the APCD system; which demonstrates that this type of data collection can be done. However, more conversation about the mechanisms for payment of this type of data generation and submission is warranted so it does not become the burden of the provider (which may be passed on to the consumer or employer).

Within the APCDs, different types of files are collected including: eligibility, provider, medical, pharmacy, and dental claims. Again, there is some variation among the states. All five of the states listed above collect eligibility, medical, and pharmacy data. Maine collects dental, and New Hampshire plans to collect dental data. Maine and New Hampshire have both developed provider files; Massachusetts, Minnesota, and Vermont plan to develop these files. According to Al Prysunka, the provider files present the greatest technical difficulty of all the types of data files in the APCDs. Correctly identifying the service provider (different sometimes from the billing provider) with name, tax identification number and/or National Provider Identification (NPI) number has posed a challenge in Maine and New Hampshire. The same provider can be identified in many different ways in the data. In Maine, a master table of provider information has been created that includes 14 data elements, reflecting all ways that the provider can be uniquely identified, such as correct provider name, Tax ID, NPI, physical location, as well as a unique provider number which is assigned and can be linked back to claims as it comes in from payers to the APCD.

Most of the claims data comes in from carriers or TPAs. Across the five states, the number of carriers submitting data to the states APCDs ranges from 18 in New Hampshire to 53 in Maine. Only 1 TPA is submitting in Massachusetts, and 45 TPAs submit to the Maine APCD. Two PBMs submit claims in New Hampshire and 2 submit claims in Vermont.

APCDs typically include data elements that identify the patient (encrypted SSN), the type of product (HMO, POS), type of contract (single, family), demographics (gender, residence), diagnosis codes (including e-codes), procedure codes (ICD, CPT), revenue codes, services dates, service provider (and id), prescribing physician, plan payments, member payment responsibility (co-pay), date paid, type of bill, and facility type. Information that is typically excluded: services provided to uninsured (few exceptions), denied claims, workers' compensation claims, premium information, capitation fees, administrative fees, back-end settlement amounts, referrals, test results from lab work, results from imaging, provider affiliation with group practice, and provider network information.

Al Prysunka highlighted a few of the greatest challenges and pitfalls with the information typically available and not available in APCDs. Al reiterated that APCD systems include only adjudicated claims (not denied claims). He

noted that there is some interest in looking at denied claims, but it is not a priority right now. Second, test results would be interesting to collect but currently there is no connection to clinical information; some payers collect lab results from national labs, but this has not been requested or passed to current APCDs. Third, there is great interest in getting more information about provider affiliation with group practice, particularly while we are seeing more primary care physicians becoming affiliated or acquired by hospital-based practices. In Maine, fields are being added to the claims data that would capture billing provider that should have information about group practice; information about billing practice and service provider would be ideal. One of the challenges with this information is the temporal nature of it. Practitioners can move from group to group over time, and this is difficult to track.

Al Prysunka also shared a pictorial representation of the distribution of states submitting data to APCDs in Maine, New Hampshire and Massachusetts (Figure 2). The map provides a sense of the far-reaching implications of APCDs data submission practices for carriers across the country. The red states represent states that are submitting claims; which is the origin of the claim and not the delivery of service. For example, a Maine resident can receive care in a Maine hospital but be covered by a policy from a carrier that is located in Connecticut, so Connecticut submits that claim to the Maine APCD.

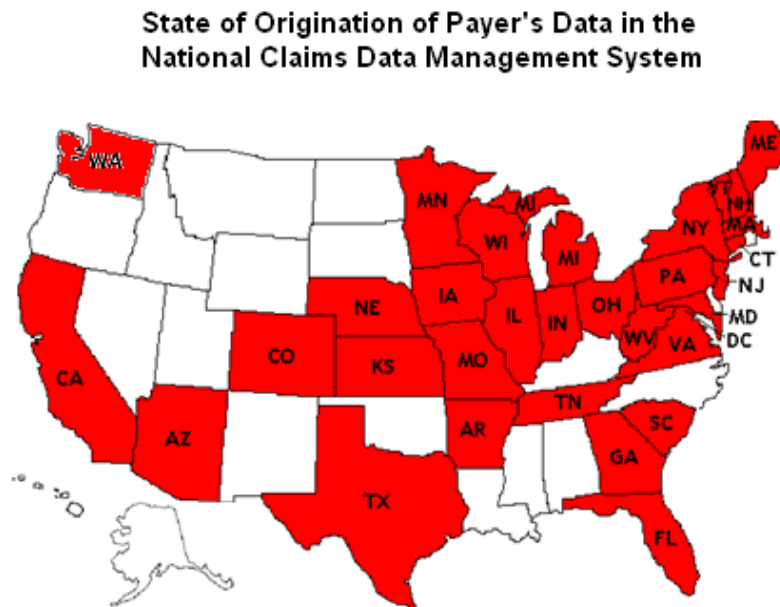


Figure 2. State of Origination of Payer's Data to APCDs in Maine, NH and MA

EXAMPLES OF APCD OUTPUT – THE VALUE OF APCDS

Patrick Miller presented some examples of how APCDs data have been used around the country (particularly in the Northeast) for public health purposes, as well as health services and public policy research.

In New Hampshire, claims data have been used to better understand the distribution of health insurance coverage. The Office of Medicaid Business and Policy in New Hampshire Department of Health and Human Services calculated the percentage of people covered by commercial insurance or Medicaid by health service area. The analysis is limited in that the New Hampshire claims data does not include residents who are covered by policies issued outside of New Hampshire – we know that data are missing for insured lives covered by non-New Hampshire carriers.

Patrick Miller presented examples of claims data analysis commissioned by the New Hampshire Citizens Health Initiative. One example was analysis of percent change in cost over 3 time periods among three large cities in New Hampshire: Manchester, Nashua, and Concord. The preliminary analysis showed wide variation over time and across cities in the percent change of cost of care for digestive conditions. Patrick Miller also shared an example of analysis of percent increase in PMPM over the course of 2005 to 2007 by hospital analysis area. This change in cost reflects the change in the average paid amount, which is the actual amount paid to the provider from the payer (not including member liability). Different states have different collection rules and release rules. Other states cannot release this kind of information to the public. In New Hampshire, this type of analysis could be helpful for negotiation by the carriers with the providers. Patrick Miller also presented an example of analysis of the change in distribution of costs by insurance type for Concord (the percent of PPO, POS, and HMP for 2005, 2006, and 2007). Another example from the tri-city New Hampshire report was graphical representation of the proportion of the annual cost increase attributable to each major disease category for the 2005 to 2007 time period.

The New Hampshire Institute for Health Policy and Practice has been working with the New Hampshire Department of Insurance since 2004 on the development of New Hampshire HealthCost, a web-based query tool that allows a user to compare typical prices for common procedures across providers in the state. Patrick Miller presented an example of a New Hampshire HealthCost query for prices of an outpatient arthroscopic knee surgery and highlighted the wide variation in the estimate of payment between Salem Surgery Center and New London Hospital. At Salem, the procedure “costs” \$3185; at New London; the same procedure “costs” \$7814 (given similar patient complexity and medium to high precision of the cost estimate). The New Hampshire HealthCost website also provides an estimate of the patient contribution (based on user input about plan type and co-pay) and an estimate of the amount that the insurance will cover. Patrick Miller was asked about whether there have been questions from the public about this site; whether customers have been confused because they don’t see the same bill that is in the claim. Patrick reported that what customers see is variation across providers and variability in the precision of the cost estimate. There are more questions from providers and policy makers about the variation.

Patrick Miller also provided an example of pricing across providers by three different payers (Figure 3). Within or across carriers, the pricing may vary significantly. For colonoscopy, carrier B is paid \$1169 by hospital B and \$2075 by hospital E. For Hospital A, carrier A pays \$2091 for the same colonoscopy that carrier b pays \$1553. The greatest difference in price was between Carrier A in Hospital C (\$2325) and Carrier C in Hospital F (\$1087); representing a more than two-fold difference in price. Employers are most interested in this cross-carrier, cross-provider variation. The New Hampshire Purchasers Group on Health, a coalition of large employers in New

Hampshire, is using this to more closely examine their healthcare costs. Payers are also interested in understanding the price variation.

| FACILITY | Carrier A | Carrier B | Carrier C |
|------------|-----------|-----------|-----------|
| Hospital A | 2,091.22 | 1,552.98 | 1,757.94 |
| Hospital B | 1,243.94 | 1,169.12 | 1,192.33 |
| Hospital C | 2,325.32 | 2,148.21 | 2,065.92 |
| Hospital D | 1,658.53 | 1,200.62 | 1,431.43 |
| Hospital E | 1,715.74 | 2,075.38 | 1,514.17 |
| Hospital F | 1,381.96 | -- | 1,087.22 |
| Hospital G | 1,906.15 | 1,942.21 | 1,949.79 |

Figure 3. Sample of cross-cutting comparison of prices across payers and providers, NH Healthcost, 2008

Maine recently released a similar HealthCost website (Figure 4), building on the analysis methodology developed in New Hampshire, and based on all payer claims data for Maine residents (including Medicare claims). The Maine HealthCost website (<http://www.healthweb.maine.gov/claims/healthcost/default.aspx>) also has a graphical feature that shows the distribution of dollars paid for common procedures.

STATEWIDE PROCEDURE PAYMENTS

Description: The chart below contains statewide pricing information across all insurance carriers and all medical providers. The chart provides average total charge and payment information, and the individual professional and facility components.

Data used for report: 12/01/2005 through 12/27/2007

| Procedure Description | CPT4 Procedure Code | Average Professional Charges | Average Professional Payments | Average Facility Charges | Average Facility Payments | Average Total Charges | Average Total Payments |
|---|---------------------|------------------------------|-------------------------------|--------------------------|---------------------------|-----------------------|------------------------|
| Arthroscopic Knee Surgery (Outpatient) View Histogram | 29891 | \$2,998 | \$1,493 | \$4,221 | \$3,698 | \$7,219 | \$5,191 |
| Biopsy - Breast (Auto Vacuum) View Histogram | 19103 | \$1,475 | \$671 | \$2,502 | \$2,190 | \$3,977 | \$2,861 |
| Bronchoscopy View Histogram | 31622 | \$4,338 | \$2,203 | \$7,304 | \$6,559 | \$11,643 | \$8,762 |
| Carpal Tunnel Release View Histogram | 64721 | \$1,729 | \$898 | \$2,341 | \$2,034 | \$4,070 | \$2,932 |
| Colonoscopy View Histogram | 45378 | \$751 | \$349 | \$1,223 | \$1,054 | \$1,974 | \$1,403 |
| Colposcopy With Biopsy View Histogram | 57454 | \$618 | \$355 | \$271 | \$258 | \$889 | \$613 |
| CT - Abdomen View Histogram | 74160 | \$288 | \$101 | \$1,164 | \$951 | \$1,452 | \$1,053 |
| CT - Chest View Histogram | 71260 | \$289 | \$93 | \$1,140 | \$968 | \$1,429 | \$1,061 |
| CT - Head (Without Contrast Material) View Histogram | 70450 | \$178 | \$66 | \$797 | \$652 | \$974 | \$710 |
| CT - Pelvis View Histogram | 72193 | \$251 | \$90 | \$1,042 | \$852 | \$1,293 | \$942 |
| Gallbladder Removal View Histogram | 47562 | \$3,442 | \$1,907 | \$7,573 | \$6,643 | \$11,016 | \$8,551 |
| Hernia Repair (Outpatient) View Histogram | 49505 | \$2,117 | \$1,323 | \$4,998 | \$4,358 | \$7,115 | \$5,681 |
| Kidney Stone Removal View Histogram | 50590 | \$3,053 | \$1,466 | \$6,566 | \$5,578 | \$9,619 | \$7,044 |
| Mammogram (Screening) View Histogram | 76092, 77057, 60202 | \$81 | \$50 | \$140 | \$127 | \$221 | \$177 |
| MRI - Back View Histogram | 72148 | \$318 | \$117 | \$1,288 | \$1,048 | \$1,606 | \$1,166 |
| MRI - Knee View Histogram | 73721 | \$253 | \$109 | \$1,162 | \$973 | \$1,416 | \$1,083 |

Figure 4. Screenshot from Maine Healthcost website

The New Hampshire Insurance Department has also produced estimates of hospital acute care cost index scores for pricing comparisons based on 2006 New Hampshire claims data and discharge data. The index score represents the comparison of the hospital average to the state average for a basket of both inpatient and outpatient services. Patrick Miller noted the high score of 1.52 for Exeter hospital, which reflects 52% higher costs

at this facility compared to the rest of the state. The lowest score was .89 for Spere Memorial, thus a 70% pricing differential in the state. Patrick suggested that this may be due to the tough market for payers in a single hospital town like Exeter; the differentials statewide may be partly explained by the limited competition in geographic areas.

With funding from the Center for Disease Control and Prevention Assessment Initiative, the New Hampshire Institute for Health Policy and Practice is augmenting the health web query system for the state with the addition of a claims data-based web query module. The claims module produces estimates for the number of claims with a particular condition or disease for a user-defined geographic area (selected counties, hospital service areas, towns, etc.), and year(s). In its current pilot form, the module produces estimates for cardiovascular disease, mental illness, access to care for adults, and access to care for children.

Using the same methodology as the HealthWRQS claims module, New Hampshire Office of Medicaid Business and Policy (OMBP) has estimated the prevalence of adult coronary disease by age for New Hampshire Medicaid and New Hampshire CHS commercial Members (private payers). The rate of disease is much higher in the Medicaid population than in the commercial population; three times higher in the older adults (age groups over age 50). Similarly, OMBP estimated prevalence of asthma by age for New Hampshire Medicaid and New Hampshire CHS commercial members. Again, the prevalence of asthma was much higher for the Medicaid population than the commercial or private payer members for most age groups. This is useful information for the Medicaid program as well as program and policy planners.

In terms of understanding variation in preventive and emergency healthcare service utilization, New Hampshire OMBP compared the percent of children ages 3 to 6 years with a well child visits across Medicaid, SCHIP, and commercial claims populations, and benchmarked with National HEDIS Medicaid and National HEDIS commercial. New Hampshire OMBP also compared outpatient emergency department visit rates across Medicaid, SCHIP, and commercial populations of children ages 0 to 18.

New Hampshire OMBP also did some payment rate benchmarking, comparing average payments across several health plans, including Medicaid. In comparing average payments across health plans for office visits for new patients (30 min), there was little variation among the private health plans, \$115 to \$130, compared to the average payment by Medicaid of \$42. Individual psychotherapy appoints (45 – 50 min) were \$71-72 for the private payers in the analysis and \$61 for Medicaid. While Medicaid uses this information for benchmarking, Patrick Miller indicated that health insurers are using this for competitive reasons. He noted that while the health plans are not directly identified in the analysis, it is possible to discern the identity of the health plan using a frequency distribution of E&M procedure codes (with an understanding of the size of the market share for each).

Purchasers are also getting interested in this information. The New Hampshire Purchasers Group on Health developed benchmark reports based on 2005-2007 claims data to understand the prevalence of health conditions, use of preventive services, and payments by service type for its members (large, public employers including University System of New Hampshire, State of New Hampshire, Municipal Association, and National Education Association-NH). Patrick Miller presented several examples of graphs that illustrate trends in major disease and use of preventive services (based on claims analysis). Patrick pointed out that employers are using this to be able to predict emerging needs in healthcare, and in working with disease management programs. He also presented some examples of benchmarking trends in high cost cases (patients with greater than \$5,000 in claims for the year) as a percentage of overall costs for company XYZ, compared to New Hampshire as a whole.

Recently, the New Hampshire Citizens Health Initiative commissioned analysis that supports the case for health information exchange. A state map of the 22 geographic Health Analysis Areas indicated a high percentage of medical service encounters leaving the “home” Health Analysis Area for both inpatient services and outpatient services. This high level of patient migration would suggest that any proposed health information system needs to match the portability of the patients. For providers using billing providers, we do not know where the service actually occurred. Patrick Miller noted some limitations with the study, including the data integrity of ambulatory services and quality that go back to the billing process.

CURRENT ISSUES

Al Prysunka indicated that there are some issues with the future development of state-based APCDs related to the lack of a standard protocol for APCDs implementation; there is no clear path for development of APCDs and no “right” way for every state (states have varying arrangements of governance and legislative authority). It is also expensive for states to figure out how to start an APCD without guidance about legislation, administrative rules development, etc.

Al Prysunka also presented the current issues and challenges with APCD data itself, including:

- Challenge of receiving data feeds from multiple insurers;
- Cross-walking insurer processing rules; no 2 insurers are alike and what is need to pay a claim, and what they keep varies from payer to payer;
- Linking pharmacy carve-outs to medical claims when the member identity can be lost from one data system to the other;
- Determining the right amount of clinical data to be included in the claims data. AHRQ has some pilots under way in some states to evaluate the integration of lab data and hospital data;
- APCDs typically do not include the uninsured; some states are exploring the best methods for getting pseudo-claims (Maine) or data on the uninsured (New Hampshire);
- Acquiring Medicare data (funding and navigation of request process); Al Prysunka noted that there is a time lag for the Medicare data and formatting the Medicare data will be an issue for each individual state.

Inconsistency in collection standards, codes, and methodology across states yields lack of interstate/national comparability of data, as well as high costs for data submitters (multiple formats) and high costs for data recipients and processors; resulting in higher costs and challenges for those who analyze the data.

In addition to these data issues, some claims are still submitted on paper; some providers do not submit all the data to the payers; some payers do not retain all of the fields submitted by the providers; most providers do not use required adopted national specialty code taxonomy; some payers do not collect back-end settlement information; and some payers use home-grown diagnosis and procedure codes.

Identification of payers, providers, and patients in the data is also problematic. The national patient ID does not exist; some states have resorted to using encrypted SSNs for subscriber/members but there is a national movement to eliminate SSN in health related databases. Despite the national payer ID movement, it continues to be difficult to track providers through mergers, buy-outs, etc.

National provider ID implementation has resulted in confusion and additional expense (at \$100,000+/year in Maine). The national provider ID is not accurate; in Al Prysunka's experience, there is a blending of billing and service provider ID making it difficult to understand where the service actually occurred. In Maine and New Hampshire, the claims data files are stripped of provider information and a separate master provider file is used, at significant cost to the states. These states have standardized provider specialty coding using national specialty taxonomy codes. The master provider file allows for linkage of the claims data to all possible data points, but this is a manual, time consuming process.

Al Prysunka stated that submission of global claims for hospital services involving hospital owned/employed physicians presents a unique problem. A global claim is a claim that contains both facility (hospital) and provider services (physician), and in the process of rolling up the information into a single claim, a physician's services become a single line in the claim. In Maine, the submission of global claims occurs for about 6% of the total claims submitted in that state, resulting in the inability to assign services to individual physicians; inability to determine accurate total price paid to the facility; and inefficient and costly use of administrative and analytical resources for high cost (cardiac, ED, and other surgeries) claims in that state.

STANDARDIZATION

While standardization cannot solve for all the problems and challenges with APCD outlined above, there are implications for data collection, data release, meta-rules development, and claims data-based tools development (like HCUP) associated with standardization. The goal of standardization is to develop consistency in collection standards and codes, establish methodology to create interstate comparability in the data, and reduce costs for submission and release of data. Principally, there are resources to be saved for data submitters, data collectors, and data users.

On behalf of the attending representatives from NAHDO and RAPHIC, Al Prysunka presented the following suggestions as initial steps toward standardization of claims data:

- For all data elements – use HIPAA transaction sets and HIPAA standard codes sets
- Flexibility for data collection entities - do not need to activate all files or elements for collection
- Additional data elements - added to end of files to minimize programming costs and to maintain harmonization
- Pre-inclusion discussions – prior to modifying data elements/files, discourse occurs with submitters to verify availability of data and cost scheduling/impacts

Al Prysunka noted that the discussion about standardization of data release could take another whole day, but he touched on it here because it is important. Data release is complicated and a lot more difficult to standardize because states vary in terms of use and rationale for data collection. In terms of data release, Al urged that administrative rules that govern release of the claims data should be generally consistent; variability impedes uniform access to data (critical to researchers and tools, such as AHRQ methodologies) and restricts inter-state comparisons. The protection of the identity of patients/members should be balanced with approved release of enough personal and demographic data to produce meaningful analyses. Rules governing release of claims data also address release of identifiable practitioner data elements (e.g. CMS currently prohibits public identification of practitioners associated with Medicare data).

RESOURCES TO BE SAVED THROUGH STANDARDIZATION OF CLAIMS DATA

Al Prysunka indicated that “it is all about money”. Whatever we can save in terms of submitting, accepting, and using the data is based on cost savings to the system (the healthcare system). To simplify the discussion, Al highlighted two groups that will reap potentially substantial savings through standardization of claims data.

Savings for data collectors (states):

- Uniform and consistent coding with national requirements (ASC X12N standards) for data submission will lead to lower costs through shared data quality methodologies and information exchange; and
- Resources expended in acquiring and mapping Medicaid and Medicare data will be reduced with uniform reporting requirements.

Savings for data submitters (payers):

- Uniform and consistent coding with national requirements (ASC X12N standards) for data submission will substantially reduce programming costs; and
- Payers could optimally submit one file vs. 50, and payers could use standard files for self-funded clients, thus, the potential for inequitable geographic operational costs are reduced.

Savings for data users (public health, policy makers, researchers, etc.):

- Data consistency allows for consistent and accurate interstate / national comparisons;
- Preparation time and costs are greatly reduced in accessing standardized data files; and
- Shared tools and analysis code become possible with a standard file format across states.

More information about the drivers of healthcare costs may drive policy and program decision-making that could reduce costs of healthcare for all.

Q & A

There were many questions throughout the “overview” portion of the meeting:

Q: Who pays?

Payers pay for data submission process. The states, via multiple funding mechanisms, pay for the collection, maintenance, and any reporting applications they require.

Q: Is there a master patient id in the existing APCDs?

Yes, in Maine, patient identification is with encrypted SSN. Massachusetts also included patient name; Maine and Vermont are adding patient ID to their data submission rule and New Hampshire will probably do the same.

Q: Who has access to the data in an APCD?

Release rules are have a different set of issues. The release is defined state-by-state. In New Hampshire, there are three different types of data sets: public use, limited use, and research data sets. Some data is freely available via portals such as www.nhchis.org and www.nhhealthcost.org.

Q: How is race and ethnicity collected?

It is typically not collected by payers currently. However, it is being collected by hospital and providers in MA and collected by HPHC. MA statute goes into effect for race and ethnicity this year.

Several carriers had questions about privacy requirements, asking whether there were any issues with new insurer rules, citing that carriers have been fined heavily for minor infractions. Denise Love and Al Prysunka reported that they are not aware of anything at the state level related to new fines. Each state determines payer fines and they are typically related to data submission timing and quality.

A question was raised about anti-trust regulations and whether some of the analytic comparisons of carriers had raised questions about anti-trust at the state level, particularly if the carriers are using data for themselves. Katherine Pelletreau offered that prices did not go up. Al Prysunka indicated that the median was used on the Maine HealthCost site (like New Hampshire HealthCost) to avoid discovery of negotiated rates. In addition, charges are suppressed, but “paid” is provided in Maine to address concerns about negotiated rates.

HEALTH QUALITY ALLIANCE

Patrick Miller then welcomed Aparna Higgins to give a brief overview of a project that she has been working on with AHIP. Funded by Robert Wood Johnson Foundation, and under direction of the Quality Alliance Steering Committee, the High Value Healthcare Project is a data aggregation project to test the feasibility of a national procedure for data aggregation across health plans for the purposes of developing NQF endorsed measures. Personal health information (PHI) remains with the health plans, while summary file with measure level data is submitted to AHIP foundation. There is a centralized reporting portal to view physician level performance information. There are 2 pilot sites, Florida and Colorado, with the intent to create consistent methodology to measure quality of care across the country. Aparna Higgins reported that data will flow at the end of 2009 and results from the pilot studies are expected in early 2010, with 21 measures. More information about the project is available at Health Quality Alliance (www.healthquality.org)

REACTION AND DISCUSSION

After Patrick Miller opened the meeting for discussion, Cynthia Wark said that it was helpful to hear about the efforts in the Northeast, and the aggregation of public and private data is of great interest for AHIP and part of the High Value Healthcare Project that Aparna Higgins described (above). She noted that all of the participants seem to agree that standardization creates efficiency in terms of getting the information (from the data) back to the providers and the consumers for decision making. She then posed the question: in the context of the national level, how do we accelerate what we are doing and stay consistent with Health Quality Alliance steering committee and the standardization efforts already ongoing (nationally consistent methods that can be applied locally)? She indicated that while this meeting is helpful and constructive, and as AHIP works with member plans to develop quality measures, it will be important to connect the efforts in the Northeast and across the country with next steps toward the goal.

The panel responded that the goal of a standard data feed in a standard format could be broken down into steps: 1) establishing standard data fields (formats, data coming from every carrier in same format), 2) standard template, which would then provide the ability to build applications and reports using the same methodology (with meta-data underneath it).

Cynthia Wark reiterated that the Board of Directors at AHIP made a decision several years ago to pursue the development of a standard because it allows for the development of standard output files and standard data models. In order to improve quality of care at the provider level and provide high-level health care and address disparities issues, AHIP identified priorities for the development of the standard data models. One of the priorities was developing standards around common interests including identification of treating physician and managing health of population (system, population, public health).

One of the carriers offered that all of us share this problem with non-standard data formats. “We have difficulty understanding what we are doing” AND managing the health of the population. Another carrier indicated that “she would like to second that”. Her organization has seen a 50% increase year-over-year for reports and extracts, and an increase in staff needs because each state has their own twist on the data extract that they require. She would like to limit the “human touch” required; it is hard to look at improvements to the data without at least a standard to relieve some of the staff, programmer and IT resources to meet the current needs. It is not just a compliance issue, but also a way to make improvements to the data that the insurer would like to make.

Bob Davis reminded the group that this is why it is important to move forward, borrowing from lessons learned from hospital discharge data from the 1970s and 1980s. First, it will be messy if the APCD systems are built state by state-by-state. Second, we need to remember that in the discharge data, we had charges, procedures, costs. We need to be careful that while we think about incorporating clinical information that we do not think about “replacing” administrative databases. He encouraged the group to think about an evolutionary process for the data.

A carrier also reminded the group that the data is only as good as data on claim; and the data starts with the providers. He asked about whether the panel had outreached to the provider community; and that without their buy-in, providers can quickly be a stumbling block. The panel responded that the states can address this; the states can be a mechanism to engage and leverage providers; this process can and should be inclusive.

Shannon Robshaw indicated that while her organization is not state-based, it has population health issues as the focus; and the group should think about organizations like hers for involvement, even if not state-based. Al Prysunka indicated that home-grown non-governmental organizations involved in APCD development can be difficult to track; he is not sure how to approach the issue of sub-state databases. Doris Lotz offered that rather than provider support, it may be the QIOs to support population health efforts. States may also be interested with respect to mandatory state government reporting, particularly hospital and plan performance reports.

Another carrier offered that while he would like to echo the importance of standardization, he would strongly encourage payers to be solicited for input. Patrick Miller indicated that up until this point, the evolution of APCD development has been largely an organic one. In individual states, there has been some collective agreement but no funding. That is why this meeting with the payers is so critical. Al Prysunka would like to more formally bounce ideas off of the payers and get feedback BEFORE state rule making. For example, discuss collection of race and ethnicity data before it is an adversarial issue. The group also discussed how insurers and insurer groups (like the Maine Association of Health Plans) are invited to, and do attend, RAPHIC meetings.

Right now, states are leapfrogging. First, Maine built an APCD in the Northeast. Then New Hampshire followed with modifications, and Maine updated its system to be consistent with New Hampshire. Then Vermont built an APCD, and they realigned the data collection rules again so that all three states would be consistent. Massachusetts was next.

It was also suggested that the best way to get the payers engaged (maybe through RAPHIC) is to first speak with them about a standard set of files, elements, and codes, and then vet any subsequent changes to the standard sets prior to amending them, which will provide feedback before the rules making process is initiated. The payers also suggested exploring a common schedule for changes, because any modifications require planning and an allocation of resources. For example, Aetna has 4 releases per year; the 2010 schedule is already set. Potentially, a state's legislation can be written to accommodate the accepted schedule. As a result of the discussion, one carrier proposed a "wish list":

- have a seat at the table;
- develop a standard for APCD data submission;
- develop a mutually beneficial schedule for revisions to standard; and
- develop an IT release schedule to accommodate the resources required to update/revise the standard file format.

One of the carriers cited that administrative expenses also need to be limited in this process (United, Aetna, and Humana concurred). Thresholds for data quality should also be defined (how often they are set and what the levels are). Most of the carriers seemed to agree that while the data layout and format may be "the easy part"; agreement in definition and resultant codes is the major issue. Issues of jurisdiction and efficiency would also have to be resolved as part of the process (e.g., payers indicated that it is easier to provide data on all the members in the state rather than only New Hampshire-issued policy members).

Irene Fraser suggested that we think of standards in both claims and clinical data, both can be integrated into any standardization vision. There is some current work specifically looking at claims data with clinical data from registries. There is some work that is coming out of Brookings. In Virginia, there is a pilot started by AHRQ. We need to keep in mind a 5-10 year vision; we could also potentially jump ahead by engaging ONC early in this conversation.

As we move forward with the vision, we also need to be mindful of what information we DO NOT need to have from the claim. The claim is a rich source of information but we need to be sensitive to the cost of the collection and submission of "unnecessary" information. For years, carriers have been aiming to pay quickly; if the provider does not provide all of the data on the claim, the payer will withhold payment will hang up the payment, but if the data needs to be complete for submission to APCDs then it could hang up the payment. So would the claim be denied or delayed? These issues would need to be resolved. Al Prysunka acknowledged that he expects that there will be tension between providers and payers if the providers are not submitting complete claims and the governmental entities collecting the data are pressing the payers to submit the missing data or pay fines. State data collection agencies must also be cognizant of minimizing the cost of any expansion of the data collected, which will ultimately be passed on the health care consumers.

There seemed to be consensus that it will be critical to establish a standard that is achievable, even if it requires lowered thresholds or staggered schedule for compliance for particular fields when the rest of the claim is clean.

Katherine Pelletreau also suggested that there will need to be a forum and method for vetting proposals to change or amend the claims data standard consistently (like MHDO board and New Hampshire Insurance Dept.) If we want to get to the next level, RAPHIC needs additional support. Anne Elixhauser reminded the group that before we get to the question of funding, we have to clearly define the purpose and that may be best done in the form of a "straw case" proposal that can be distributed within this group for feedback.

NEXT STEPS

Aetna , Cigna, Humana, Harvard Pilgrim, Regence, and United agreed that this is urgent for their organizations. To bring folks up to speed with harmonization and then engage stakeholders in areas of confluence, the proposed next steps are:

1. Establish working group, starting with RAPHIC and move up to national level of conversation
 - a. Develop timeline, budget, and funding plan
 - b. Develop collection standards for files, fields, and codes
 - c. Identify process for implementing standards
 - d. Share findings and plan with Stakeholder group
 - e. Develop business plan and vision for future
 - i. What's good for us and what's good for them – find confluence
 - ii. Find areas of interest and build around them
 1. Standardization of file/data
 2. Provider identification
 3. Consideration of economy of national repository
 - iii. Business plan to achieve objectives; business case and plan (value will be seen)
 - iv. Consider national regional implementation work group – standardize performance measure work group
 - v. Cross-fertilization with Quality Alliance Steering Committee (healthqualityalliance.org)
2. Stakeholder group (today's participants and technical staff)
 - a. Review findings of working group
 - b. Maintain momentum for standardization

Conference call will be held in a few weeks to discuss plan, and new slides and contact information will be resent and posted on www.raphic.org.

ⁱ The social security number is an algorithm; Maine and New Hampshire require payers to use the algorithm so SSN is encrypted the same way and tracks the same across the carriers; the SSN is double encrypted before data is released to researchers.