

REVIEW OF STANDARDIZATION PLAN FOR  
ALL-PAYER CLAIMS DATA COLLECTION

MEETING MINUTES

JULY 30, 2009

National Association of Health Data Organizations  
Regional All-payer Health Information Council  
Attendees of May 6 meeting at AHIP

Funded by Agency for Healthcare Research and Quality

Patrick opened with a brief review of the “next steps” from the May 6 meeting and reminded the group that the interest in standardization was apparent at the May meeting – there are benefits for all parties that use healthcare claims data. For that reason, a plan for standardization of claims data was drafted as part of contract from AHRQ; the plan was sent out prior to the call. The goal for the meeting was to review and discuss the draft standardization plan and discuss next steps.

OVERVIEW OF DRAFT STANDARDIZATION PLAN

(Slides from the meeting are available at <http://www.raphic.org/resources.html>)

Patrick provided an overview of the 3 stage process described in the drafted standardization plan:

- Stage 1: Assess what data elements are captured, and how, for existing and developing state APCDs
- Stage 2: Build consensus among working group members about data elements and definitions
- Stage 3: Bring the consensus standards to a formal standards organization

Patrick noted that this process needs to move along rather quickly; TN is in the process of looking for a vendor and Oregon has passed legislation for development of an APCD since we last met in May. Establishing the workgroups should be fairly straightforward; building consensus will be the harder part. Once there is consensus, the intention is to bring the standards to formal data standards organizations.

## STAGE 1 – ASSESSMENT OF DATA ELEMENTS

In stage 1, a workgroup would be established, composed of States currently collecting and developing APCD, data submitters (insurers, public payers, third party administrators, pharmacy benefit managers), and a multidisciplinary group of data users (researchers, consultants, purchasers, business groups). The function of the workgroup is to determine what data elements currently exist in APCD and what data elements are on the near-future wish list for APCD. This list of elements will form the basis of the data elements standards that need to be developed.

The working group will review prior work that has been completed to achieve standardization, identify areas of convergence for the needs of payers, states, researchers, and other data users, and identify data elements of interest for potential future addition to the data set, as well as investigate which data standards are appropriate for APCD data elements.

Based on that work, the Working Group will develop a plan for standardizing APCD that will include: a potential file layout for standard APCD data elements and options for flexibility for adding different elements, potential solutions for data elements that are problematic, a summary of data standards that could be used for APCD collection, and a plan that will be reviewed by Stakeholder Group.

Some of this work has been started by RAPHIC; the matrix that is available on the RAPHIC website can be used as a foundation for this inventory and comparison of data elements. In response to questions about the level of specificity for the data file layouts, Patrick indicated that the detail would be included in the discovery, starting with fields and addressing selection criteria.

The Stakeholder Group will be comprised of:

- Agency for Healthcare Research and Quality
- The National Association of Health Data Organizations
- Regional All-Payer Healthcare Information Council
- Health Insurance: Aetna, Cigna, Humana, United Health Care, Harvard Pilgrim Healthcare
- The Louisiana Healthcare Quality Forum
- Maine Association of Health Plans
- Maine's Claims Data Processor: The Maine Health Information Center
- The National Governor's Association
- The National Conference of State Legislatures
- The Centers for Medicare and Medicaid Services
- America's Health Insurance Plans
- Provider representation (e.g., American Hospital Association, American Medical Association)

In terms of the members of the group, another question was raised about data elements housed in entities that are not carriers, like providers, etc. Maybe the Stakeholder or Work Group should be expanded to include groups that are needed to address this issue. The suggestion was made to ALSO include other insurers if interested; those listed (above) are those who have expressed interest thus far but there may be others that are interested.

## STAGE 2 – CONSENSUS BUILDING

Stage 2 is the heart of the work. In Stage 2, the Working Group will vet the data element standardization recommendations from Stage 1 with a larger group of states and other relevant organizations to build consensus across states to harmonize data collection. Other groups to be consulted in the vetting process will include National Committee for Vital and Health Statistics, Public Health Data Standards Consortium, Office of the National Coordinator.

After consensus is established, NAHDO identifies the appropriate standards bodies (e.g. ANSI ASC X12N, NCPDP, HL7), and begin to work with them to formalize standard. For data elements that are identified as non-standard or for those that would improve with updated standards, NAHDO would work with the states and their stakeholders to gain consensus on the proposed standards. The consensus statement can serve as the “temporary” standard for APCD while the formal process of establishing standards continues.

The intention here is to involve as many states as possible because states are developing APCDs on their own. Make states aware that the standards are coming and once they exist, it will facilitate claims data submission going forward.

## STAGE 3 – FORMALIZE STANDARDS

The formalization of claims data standards will be similar to the standardization work that has been done with hospital discharge data, and the work that has been initiated by RAPHIC with comparing health care claims data elements collected in the New England states (to date).

In the course of stage 3, NAHDO will engage the relevant Data Standards Maintenance Organizations (DSMOs) and the content standards groups to adopt these consensus standards: National Uniform Billing Committee (NUBC), National Uniform Claims Committee (NUCC), National Council for Prescription Drug Programs (NCPDP).

On an ongoing basis, there will continue to be a need to assess new data elements and the cost/benefit analysis of adding data elements, and NAHDO has the relevant experience to facilitate those conversations.

## PROPOSED TIMELINE

Stage 1: 3-6 months  
(Assess what data elements are captured, and how, for existing and developing state systems)

Stage 2: 9-12 months  
(Build consensus among working group members about data elements and definitions)

Stage 3: 9-12 months  
(Bring the consensus standards to a formal standards organization)

***Total Time Required: 21-30 months***

## RESOURCES REQUIRED

1. One (1) FTE Project Director
2. One (1) FTE Standards Project Manager
3. One-half (0.5) FTE Program Support Assistant
4. Travel Support
5. Meeting Support
6. Materials
7. Contracts for technical expertise for individual standards group (e.g., pharmacy), if needed
8. Phone

***Estimated Annual Cost: \$384,931***

## REACTION AND DISCUSSION

Mary Taylor indicated that the 3 stage process makes sense; the approach is similar to what she would have thought. Mary also suggested that cost-benefit analysis on ongoing data analysis is critical; priority setting may have to happen in consensus building process. She also raised the question about where the staff would physically reside. Patrick suggested that staff would primarily reside at NAHDO but that was not firm. Mary also urged that we need to have the conversation about funding. Health plans have a stake in the standardization of claims data; as do other constituencies; as do states.

Annette Gabel added that it takes time to build a standard and implement; and asked if there will be funding for both development and implementation.

A question was raised about the power to influence states to use the standard. Annette offered that once a standard is designed, having that standard can be used to influence a regulatory body. For states, stakeholders can provide comment during the process of establishing legislation and rules that may influence the regulatory body and its decision making about the standard.

A question was raised about whether there is any federal influence to the adoption of standards. Linking to entities like ONC should be helpful. Perhaps, as with HIPAA standards and federal regulation, federal committees may be the way to raise the standard to a national level. Perhaps, a standards body could initiate the process, and get states to come along?

Another point was raised that there is also an opportunity for proliferation beyond state government. Medicaid has requirements for reporting. The data definitions might be the same; might be something that Medicaid can use. Are there opportunities at the federal level for influencing this, too? Is Medicare within the scope of this plan? Denise indicated that we are not sure about CMS' position about the importance of alignment between Medicare and claims. Perhaps there is a role for standards body to determine if Medicare can be put into alignment or if they can migrate to alignment.

The question was raised about how do we decide about how to get the funding? Patrick reminded folks that today we would like to ensure that the plan makes sense to folks, so we are able to shop the plan

around in an effort to get funding. For funding, Anne indicated that she was pretty sure that AHRQ would not be able to foot entire bill; perhaps a portion.

Regarding funding, Bob Davis suggested that this is really a “Dollars and sense” reason why it’s a good thing. There is great opportunity associated with this work. The process to date has leveraged work of other groups (NAHDO, RAPHIC); leveraging the states at no charge. However, an institutionalized approach needs dedicated resources going forward.

Regarding the plan for standardization, Cynthia Wark volunteered that AHIP could gather thoughts as well. Cynthia also suggested that it is important to understand what is happening with standards at the federal level, including at CMS; it will be important to continue to reach out to ONC and federal systems. There seems to be more national attention to consolidated health informatics, a significant effort aimed at reaching consensus with standards within federal government: DoD, VA, HHS. Cynthia also indicated that the proposal looked about right to her, based on work she did at the federal level. In a project she worked on, a federal agency, like National Committee Vital Health Statistics, would take standards after consensus was developed by their standards workgroup to ensure vetting and alignment with private sector. Cynthia urged the group that we need to understand where the federal standards work is today to determine if there could be alignment.

Cynthia also noted that health insurance plans get asked for data a lot, for lots of different efforts; this is the impetus for the national data aggregation efforts and why RWJ is invested; the solution there was to develop software to be used by plans to produce standard output files (which don’t require transmission of PHI).

A question was raised about whether there is intention to standardize data release policies. Patrick indicated that Data Use/Release is a different conversation. Data release is very state specific; we are not talking about release right now because it is very politically charged. If we are not talking about release then we may want to remove language about potential for a national database with every claim; states may be uncomfortable with this potential since they take very tight control of data (language has been taken out of the draft plan).

Another question was asked about whether the plan includes any type of “sales” effort – something you can start with states that are adopting rules. Maybe MHIC and other vendors would pay a nominal fee for access to the standard.

Next steps:

- Modify the plan to include applications of the data
- Send final report to the group and post on RAPHIC
- Explore additional ideas for funding
- Jo will touch base with Annette Gabel from Medco
- Interest in stakeholder group meeting again if funding is available for a meeting