

## All-Payer Claims Databases Standardization Plan

### What are All-Payer Claims Databases?

APCDs are data systems that collect claims data from commercial and public payers. These databases in conjunction with existing state discharge data systems hold the potential for a much deeper understanding of patterns, quality, and cost of care across entire populations. The source of the data is transaction systems that process the payment of claims for private and public payers. In addition, some states are developing methods to capture data for uninsured individuals.

While the contents of individual states' APCDs can vary, they can include data derived from medical, eligibility, provider, pharmacy, and dental files. The medical and healthcare related data elements typically include diagnosis codes, the types of care received (procedure and pharmacy codes), the type of insurance product (HMO, PPO, POS), facility type (hospital, office, clinic), "cost" amounts (charge, paid, member liabilities), and provider type.

APCDs are being built and used around the country, and 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, 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 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 that produces estimates for the number of claims with a particular condition or disease for a user-defined geographic area.

### Why standardization?

While APCDs represent a robust set of data to use to advance the understanding of cost and quality of healthcare, there are concerns about the lack of standardization of the data across states. Data are being collected by different methods and with different definitions state-to-state. This non-uniform approach to develop APCDs will diminish the overall potential for these databases, and may lead to significant additional expense for the payers who are submitting the data (especially those operating in multiple states). Conversely, collecting APCDs similarly across states will potentially enable cost-effective regional databases.

While standardization does imply that the file structure (data element positioning and field lengths) would be identical from state to state, it does not mean that each state must collect the data for each listed element. Standardization will result in definitions that ensure that states collecting the same data will do so in the same manner. Individual states will likely decide to add data elements that not every state wants. In this case, standards for modifying the standard file structure to position and define additional data elements will be developed, but states are not obligated to collect the data associated with the additional elements.

It is important to acknowledge that the current national dialog about health care is impacting all the standards development and data content organizations. In particular, the emphasis on the important role of electronic health records in reforming our health care system will impact all health data standards in the future. This effort will clearly impact all potential users of health data including implementers of APCD systems. In acknowledging the potential short and long term effects this national effort will have on any future development of health related systems, it is important to stay informed on the progress of these national initiatives. For this reason, it will be critical to work collaboratively with the United States Health Information Knowledgebase (USHIK; <http://ushik.ahrq.gov>) project, which has established a metadata registry that enables comparisons across standards data organizations in terms of collection of a data element.

### How can standardization be achieved?

We propose a **3-stage process** to create data standards for APCD:

#### Stage 1: Assess what data elements are captured, and how, for existing and developing state systems

The foundation for Stage 1 has been set by the work led by Al Prysunka of the Maine Health Data Organization through the Regional All-Payer Healthcare Information Council (RAPHIC). The efforts toward standardization of the data elements have focused on the New England states, and have led to the states of Maine, New Hampshire, Massachusetts, and Vermont collecting their common data elements in the same way. Details of those data elements can be found at: [http://www.raphic.org/resources\\_data-collection.html](http://www.raphic.org/resources_data-collection.html).

To build upon this existing work, a Working Group should be established 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. This work should be reviewed by a larger Stakeholder Group.

## The Working Group

The working group should include representation from different perspectives, including:

1- *States collecting and developing APCD*

States will be familiar which data elements are needed to support state-level policy work, how changes will impact the state systems, and the process required to implement changes.

2- *Data submitters* (insurers, public payers, third party administrators, pharmacy benefit managers)

Data submitters will understand the availability of, and caveats for, existing and proposed data elements. They will also be able to explain the process, resources, and time needed for new elements to be added to the data submission.

3- *Data Users* (researchers, consultants, purchasers, business groups)

Data users will provide important information about the utility of the different data elements and the wish list for data elements that can be used to answer research questions.

The Working Group will work through Stage 1 of the standardization process by:

- Reviewing prior work that has been completed to achieve standardization.
- Identifying areas of convergence for the needs of payers, states, researchers, and other data users.
- Identifying data elements of interest for potential future addition to the data set.
- Investigating 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

The Working Group's summaries and findings will be shared with, and reviewed by, the Stakeholder Group.

## The Stakeholder Group

The Stakeholder group includes the participants of the May 6 "Forum to Establish a Plan for Standardizing All-Payer Claims Data Collection", held in Washington, DC. The stakeholder group includes:

- a. Agency for Healthcare Research and Quality
- b. The National Association of Health Data Organizations
- c. Regional All-Payer Healthcare Information Council

- d. Health Insurance Companies: Aetna, Cigna, Humana, United Health Care, Harvard Pilgrim Healthcare and others
- e. The State of Maine’s Claims Data Processor: The Maine Health Information Center
- f. The National Governor’s Association
- g. The National Conference of State Legislatures
- h. The Centers for Medicare and Medicaid Services
- i. The Louisiana Healthcare Quality Forum
- j. Maine Association of Health Plans
- k. America’s Health Insurance Plans
- l. Provider representation (e.g., American Hospital Association, American Medical Association)

### **Stage 2: Build consensus among working group members about data elements and definitions**

After the working group has developed its draft of APCD data elements and standard definitions, those draft recommendations need to be vetted with a larger group of states and other relevant organizations. The goal of this second stage of vetting is to build consensus across states to harmonize data collection.

The National Association of Health Data Organizations (NAHDO) has a long history of building consensus around the definitions for data standards. NAHDO can work with other key organizations, such as the National Committee for Vital and Health Statistics and Public Health Data Standards Consortium, to engage other relevant groups in the conversation about data collection standards for APCD, and develop potential solutions for data elements that are problematic with the data stewards. Also, the members of the Working Group and the Stakeholder group will be important in assisting in the vetting process by reviewing the work with their constituencies and promoting the standards.

For emerging data elements, NAHDO would be able to identify the appropriate standards to use (e.g. ANSI ASC X12N, NCPDP, HL7). 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. **This consensus statement can serve as the “temporary” standard for APCD while the formal process of establishing standards continues.**

### **Stage 3: Bring the consensus standards to a formal standards organization**

Once broad consensus on the data element standards and formats is achieved, NAHDO would engage the relevant Data Standards Maintenance Organizations (DSMOs) and the content standards groups, such as the National Uniform Billing Committee (NUBC), National Uniform Claims Committee (NUCC), and National Council for Prescription Drug Programs, as needed, to adopt these consensus standards. NAHDO also has a long history working with those standards organizations.

### Continuing work

These 3 stages represent a process by which standards for APCD can be created. However, there must be a way for developing flexibility in standards for emerging data elements as APCDs continue to evolve. There will continue to be a need to assess new data elements and the cost/benefit analysis of adding data elements. NAHDO also has experience playing that role.

### What resources are needed?

Establishing standards for APCD is a worthwhile goal, and one that will require appreciable resources. We propose:

1. One (1) FTE Project Director: The Project Director will be responsible for developing and maintaining an overall work plan for the standardization process. This will include developing the Working Group and establishing the Stakeholder Group. The project manager will be the lead contact for the entire project, developing the necessary materials to support the work.
2. One (1) FTE Standards Project Manager: The Standards Project Manager will be responsible for identifying standards templates appropriate for the APCD elements. This person will work with the Working Group to define individual elements and link those elements to the appropriate standards bodies. The Standards Project Manager will also be the key person to bring the elements through the formal standards development processes within the standards organizations.
3. One-half (0.5) FTE Program Support Assistant: The program support assistant will work with the Project Director and Standards Project Manager to establish the meeting schedule, prepare meeting materials, conduct necessary background research, and organize meetings.

Estimated cost of salary and fringe benefits: \$202,720

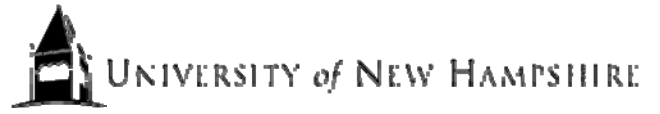
The project will also require funds to support:

1. Travel Estimated cost: \$10,000
2. Meeting support Estimated cost: \$1,500
3. Materials Estimated cost: \$750
4. Contractor for technical expertise for individual standards group (pharmacy), if needed: \$50,000
5. Phone Estimated costs \$500

Estimated annual direct costs: \$265,470

Estimated annual indirect costs: \$119,462

Total estimated annual costs: \$384,931



## **Timeline**

Stage 1: Assess what data elements are captured, and how, for existing and developing state systems

*Time required: 3-6 months*

Stage 2: Build consensus among working group members about data elements and definitions

*Time required: 9-12 months*

Stage 3: Bring the consensus standards to a formal standards organization

*Time required: 9-12 months*