The Imperative for an All Payer Claims Database (APCD)

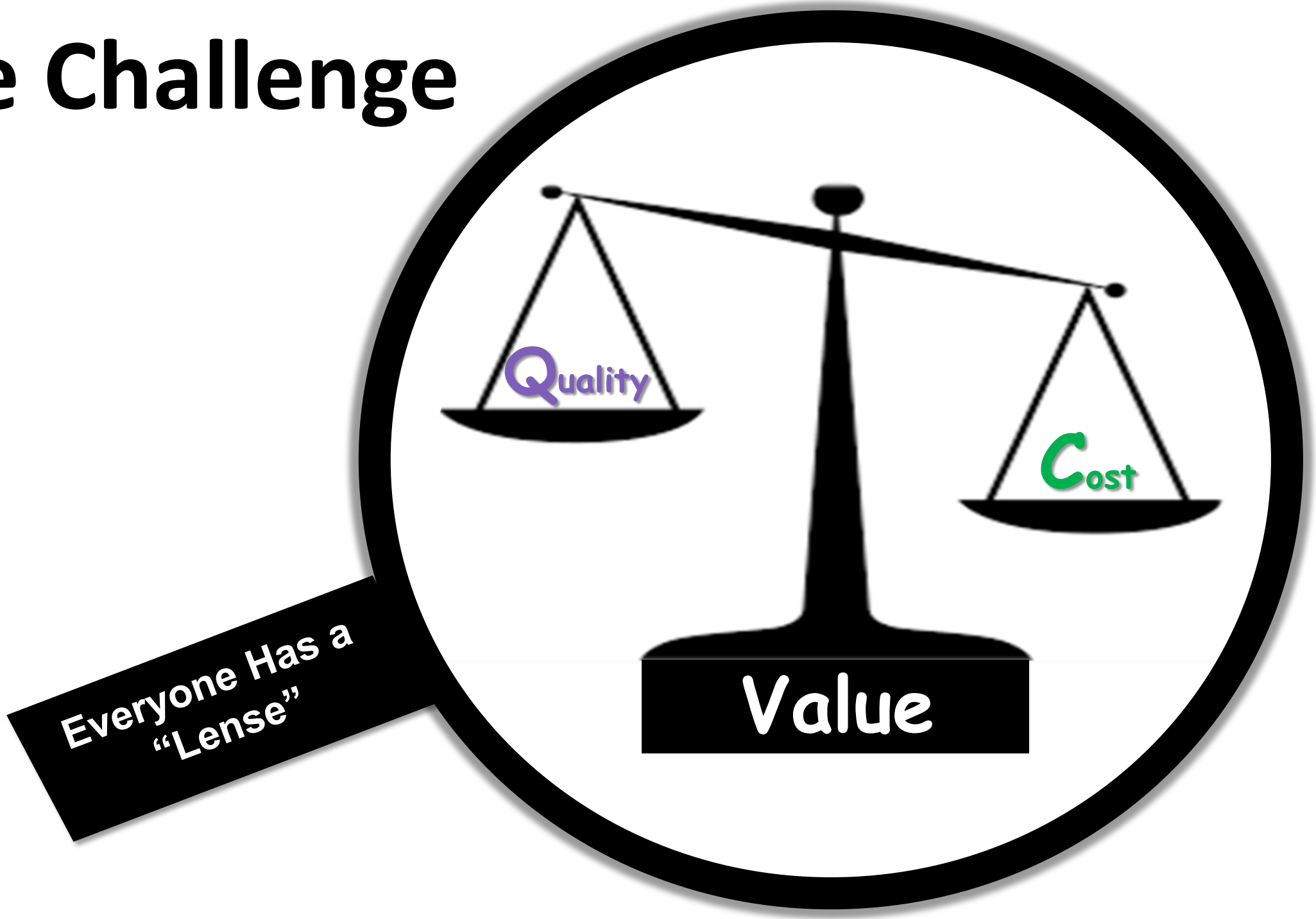
Improving **HEALTH** For Kentuckians

August 1, 2023

WHY

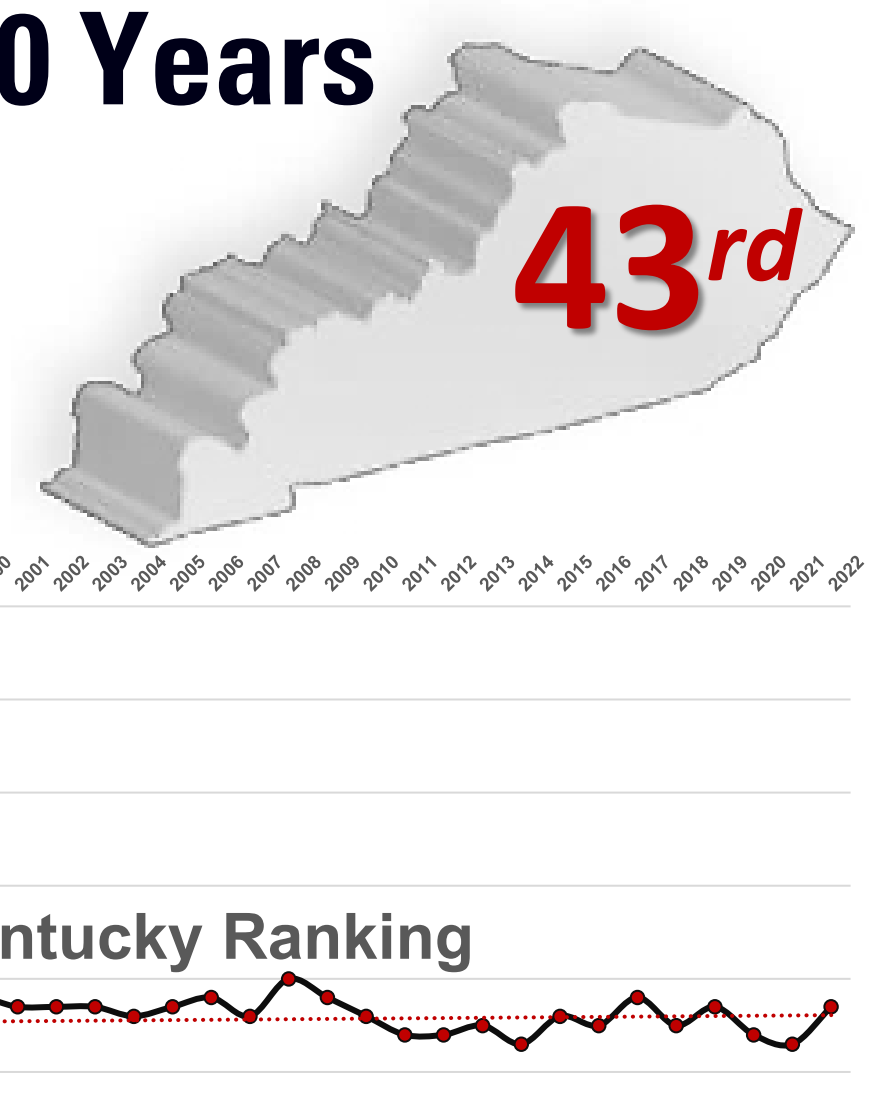
The vision for the *All-Payer Claims Database* is to ***improve the HEALTH* of Kentucky's children, families, communities, and workforce** by providing complete and transparent information about healthcare utilization and outcomes

The Challenge



Haven't Moved the Needle in 30 Years

	KENTUCKY RANK
DRUG OVERDOSE DEATHS	49
NUTRITION & PHYSICAL ACTIVITY	49
DENTAL CARE	49
MULTIPLE CHRONIC CONDITIONS	48
OBESITY	48
PREVENTABLE HOSPITALIZATIONS	47
ADVERSE CHILDHOOD EVENTS	46
PREMATURE DEATH	46
TEEN BIRTHS	45
HIGH SPEED INTERNET	44
FOOD INSECURITY	42
NON-MEDICAL DRUG USE	41
ECONOMIC HARDSHIP INDEX	40



America's Health Rankings

2022

It’s About How Do We *IMPROVE*

Where Does Data Come From?

Administrative Data Sets

-Medical Claims

-Prescription Pharmacy Claims

-Behavioral Health Claims

-Vision/Dental Claims

-Eligibility Data

-Provider Data

Other Data Sets

-Electronic Medical Records (EMR)

-Health Information Exchanges (HIEs)

-ADT, CCD, Pathology, Other Laboratory, etc.

-Registries: Chronic Disease, Immunizations, etc.

-Self-report Data (HRA, PHQ-9, SF-8, etc.)

-Information/Data Collected with:

Case Management, Disease Management,
Medication Therapy Management, EAP, etc.

-Logistics (Time Clock, Tracking, Throughput, etc.)

-Internet of Things (IOT)-Devices

-Unstructured Data (Texts, Social Media, etc.)

Typical Goals of APCDs

- Public reporting on utilization, spending, and quality
- Facilitating transparency and fiduciary responsibility
- Measuring quality of care
- Monitoring the impact of legislation
- Improving the health of the population
- Reducing or controlling the growth of costs
- Supporting health system change such as implementation of accountable care organizations or other alternative payment models
- Evaluating state health reforms
- Furthering research about health care in the state or the health of the state's population

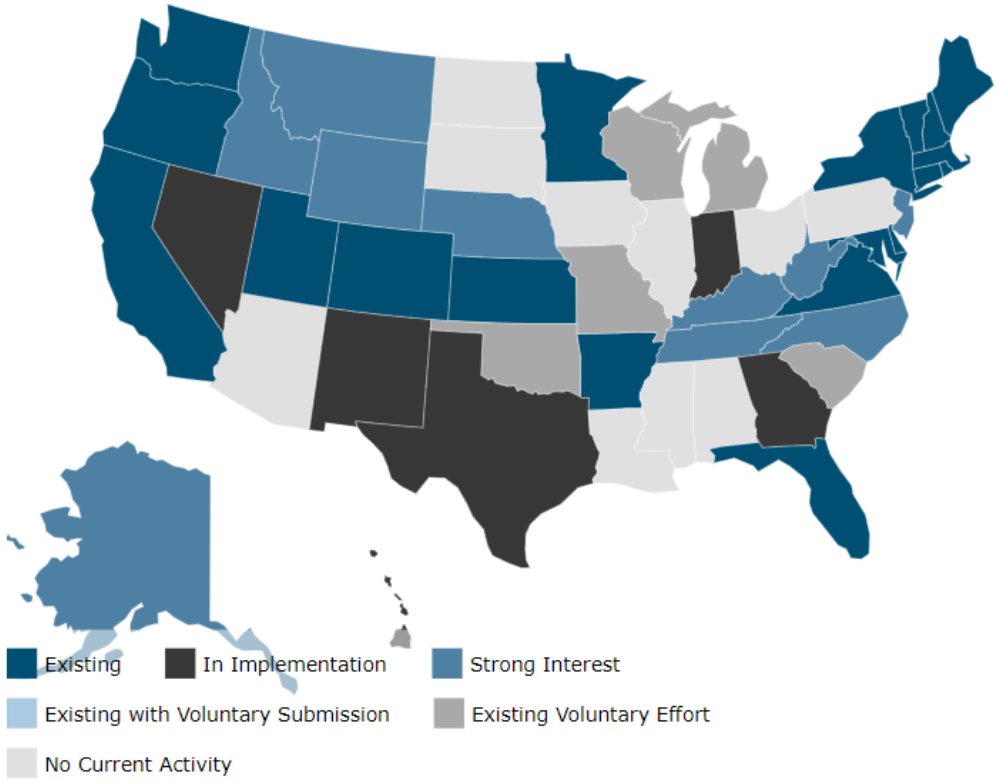
What are the Uses *AND* Who are the Users?

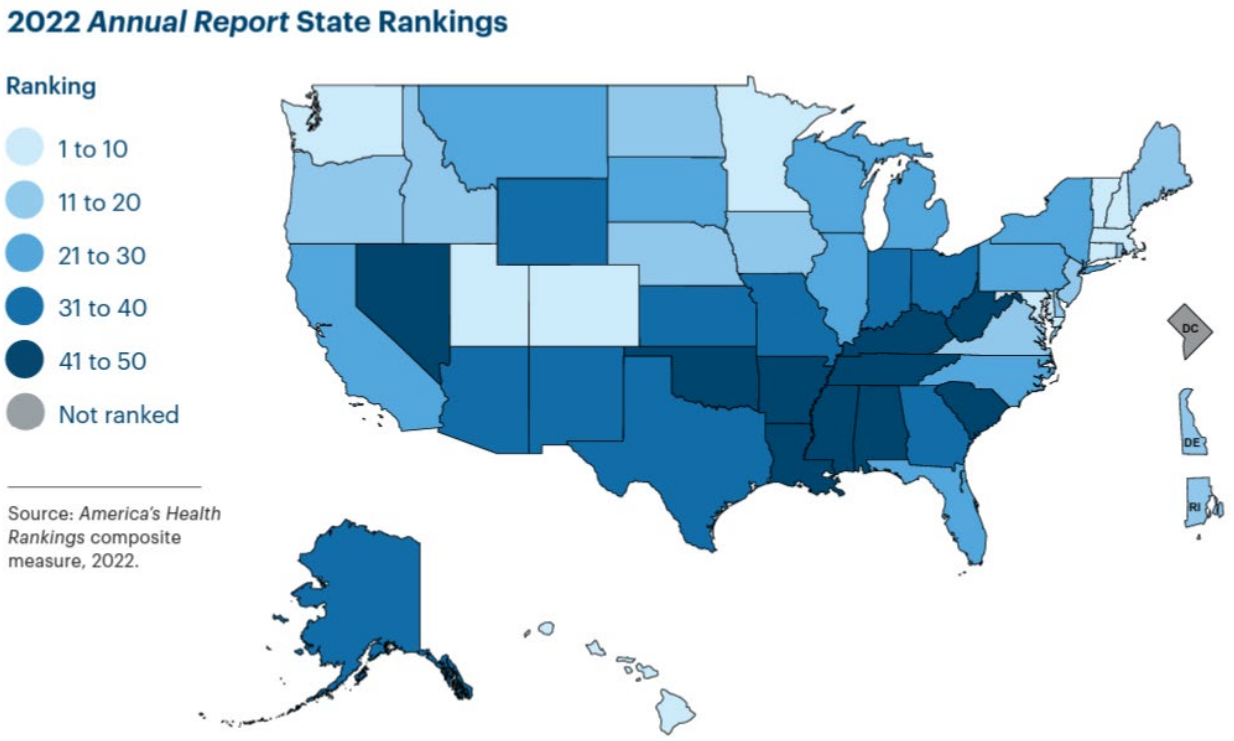
APCD Data Users	APCD Data Uses							
	Health Care Spending and Cost Trends	Delivery System Performance	Health Care Services Utilization	Population Health	Disease Prevention	Insurance Coverage	Financial Stewardship	Other
Physicians & Other Care Providers	✓	✓	✓	✓	✓	✓	✓	✓
Emloyers and Other Healthcare Fiduciaries	✓	✓	✓	✓	✓	✓	✓	✓
Federal, State, and Local Community Entities	✓	✓	✓	✓	✓	✓	✓	✓
Private Companies	✓	✓	✓	✓	✓	✓	✓	✓
Academic Institutions	✓	✓	✓	✓	✓	✓	✓	✓
Policy Researchers	✓	✓	✓	✓	✓	✓	✓	✓
Other	✓	✓	✓	✓	✓	✓	✓	✓

How APCDs Benefit Employers

- **Improve health** of employees while **controlling costs**.
- Assist employers in implementing new fiduciary and transparency rules that require employers to pay a **“fair price”** for health benefits.
- Assist employers with **benefit design and planning**.
- One access point to understand **quality, affordability, and equity** in healthcare.

State Rankings and APCD Implementation

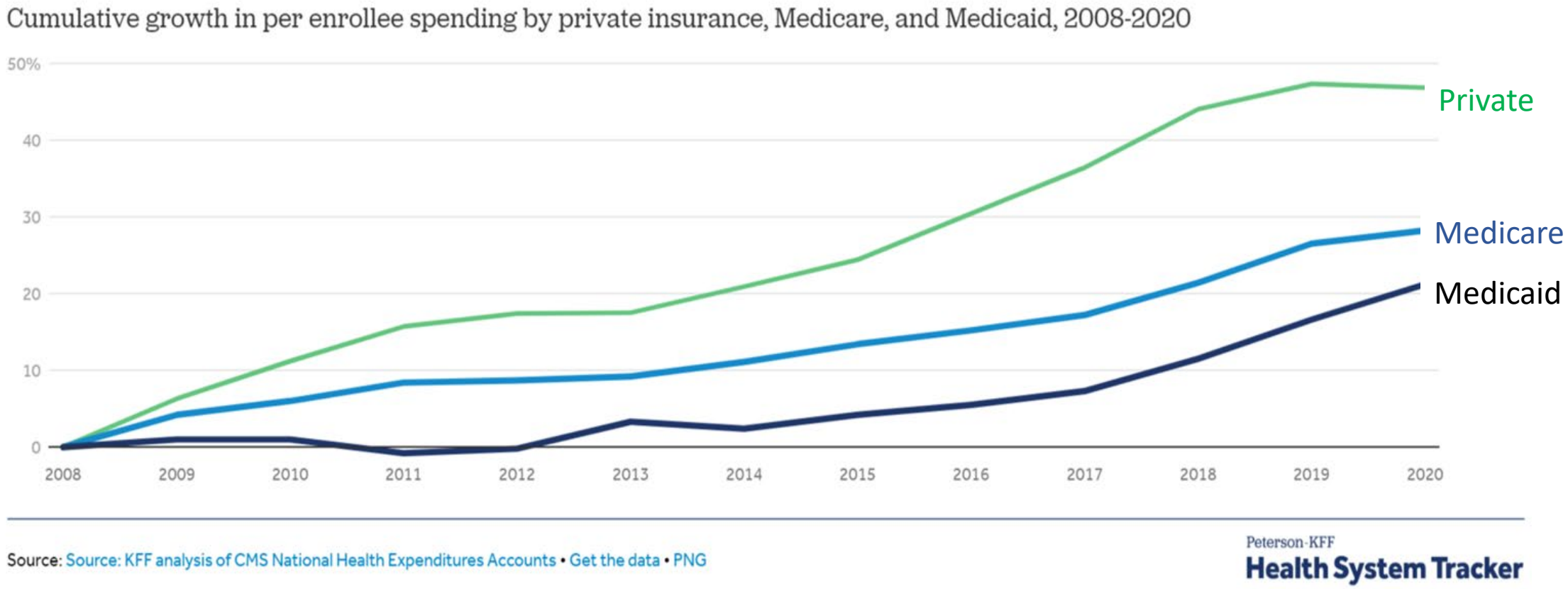




Kentuckiana Health Collaborative

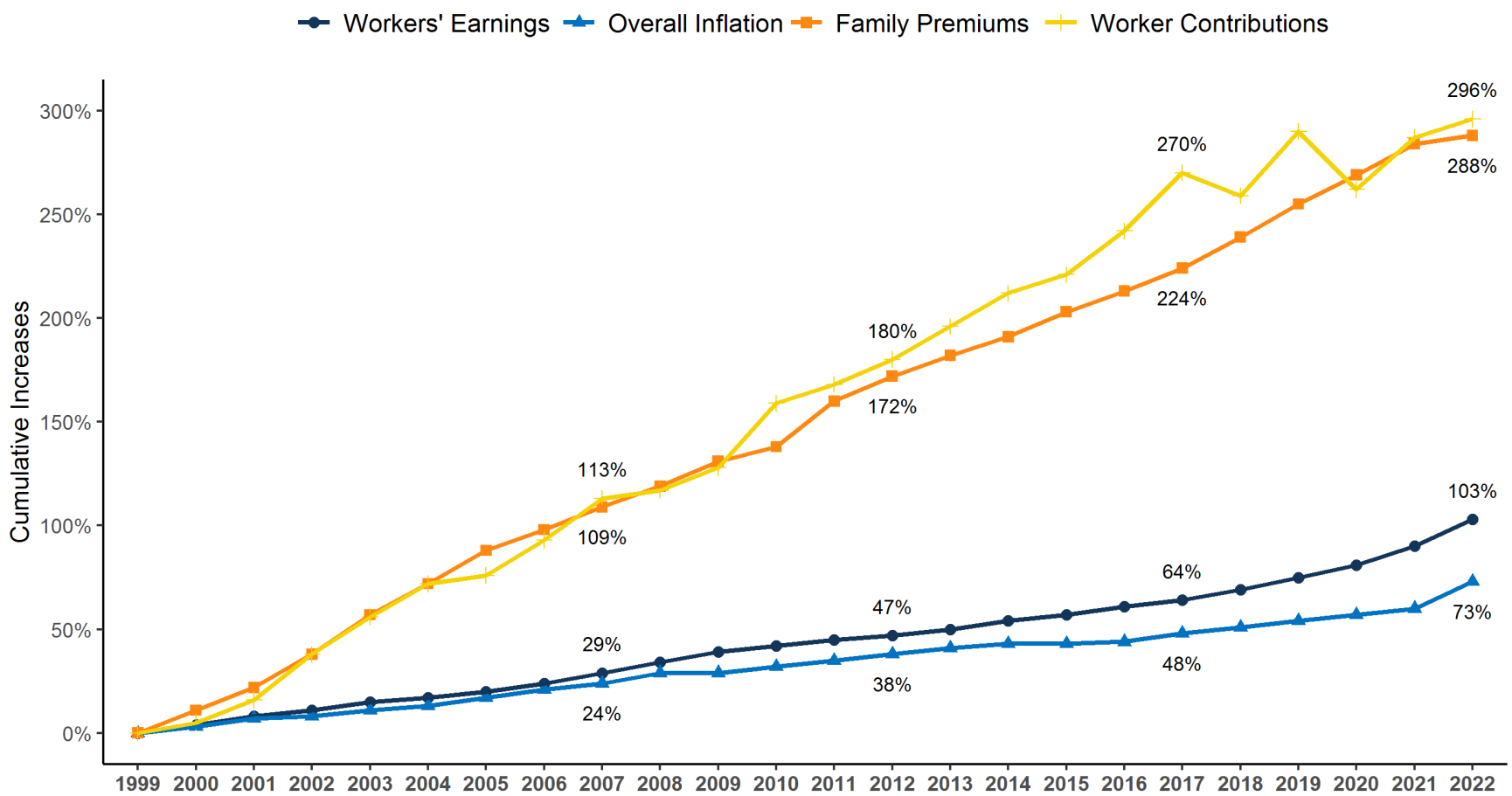
Building a Bridge to Better Health, Better Care and Better Value

On a per enrollee basis, private insurance spending has typically grown faster than Medicare and Medicaid spending



https://www.healthsystemtracker.org/chart-collection/u-s-spending-healthcare-changed-time/#Relative%20contributions%20to%20total%20national%20health%20expenditures,%202020

Cumulative Increases in Family Premiums, Worker Contributions to Family Premiums, Inflation, and Workers' Earnings, 1999-2022



SOURCE: KFF Employer Health Benefits Survey, 2018-2022; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017. Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation, 1999-2022; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 1999-2022.

Kentucky Has the Highest **Family** Premium of Our Neighbors

Location	2018 Total Annual Premium	2019 Total Annual Premium	2020 Total Annual Premium	2021 Total Annual Premium
1. Kentucky	$19,277	$20,612	$20,396	$21,531
2. Virginia	$19,512	$19,865	$20,458	$21,348
3. Indiana	$19,551	$21,169	$20,125	$21,281
4. Ohio	$19,640	$19,621	$20,088	$21,102
5. Illinois	$20,407	$20,659	$21,775	$20,878
6. Tennessee	$17,663	$18,748	$18,424	$19,593

KFF State Health Facts. Source: U.S. Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. Medical Expenditure Panel Survey Insurance Component (MEPS-IC).

APCD Myths and Misunderstandings

Myth number 1: We don’t need an APCD, we already have all the data available from other sources

We do have access to some data, but not in an integrated system where data is linked to provide population level analysis

Medicare : Only covers elderly patients

Medicaid: Only covers the needy

Hospital Discharge: No treatment data across continuum of care; only hospital-based care

Behavioral Risk Factor Surveillance System: No individual-level data; only data for survey items

Registry Data: missing demographic indicators, screening data, etc.

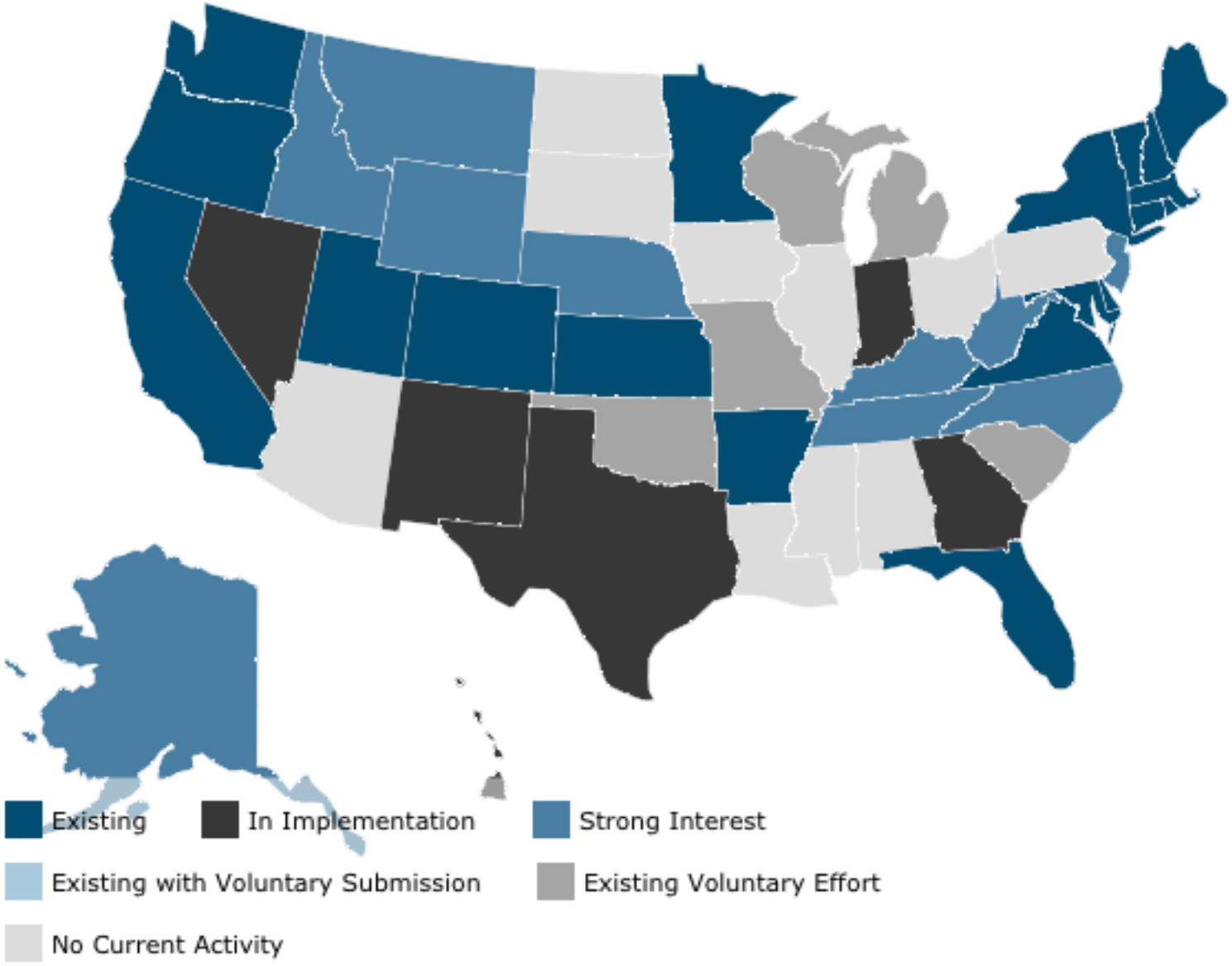
DATA needs to be linkable across systems to identify care gaps and generate quality measures for communities

APCD Myths and Misunderstandings

Myth number 2: APCDs are a partisan issue

Current State of APCDs

States have adopted APCDs to meet the critical information needs of State agencies, inform health care and payment reform initiatives, and support price transparency initiatives to meet the needs of consumers, purchasers, and State agency reform efforts



State APCD Implementation 2023

Use Case Examples

- **Arkansas** added new data elements to its APCD in 2017 to allow it to perform deeper analyses around medical marijuana use, recently profiling patient characteristics and conditions.
- **Florida's** APCD is focused on transparency measurement for health quality, pricing, and health outcomes.
- **Oregon** released an overview of 52 use cases for its APCD, including how its insurance department has used the APCD to track primary care spending trends.
- **New Hampshire's** insurance department is using its APCD to revamp its network adequacy requirements.
- **Texas's** APCD is focused on health system spending and utilization, state policy and regulatory analysis, value-based care delivery, public health monitoring, and health care research and evaluation.
- **Utah** uses its APCD to create dynamic quality measure comparisons for state clinics. Measures are then profiled in maps, with data available for download.

APCD Myths and Misunderstandings

Myth number 3: APCDs are used to regulate and cap commercial prices

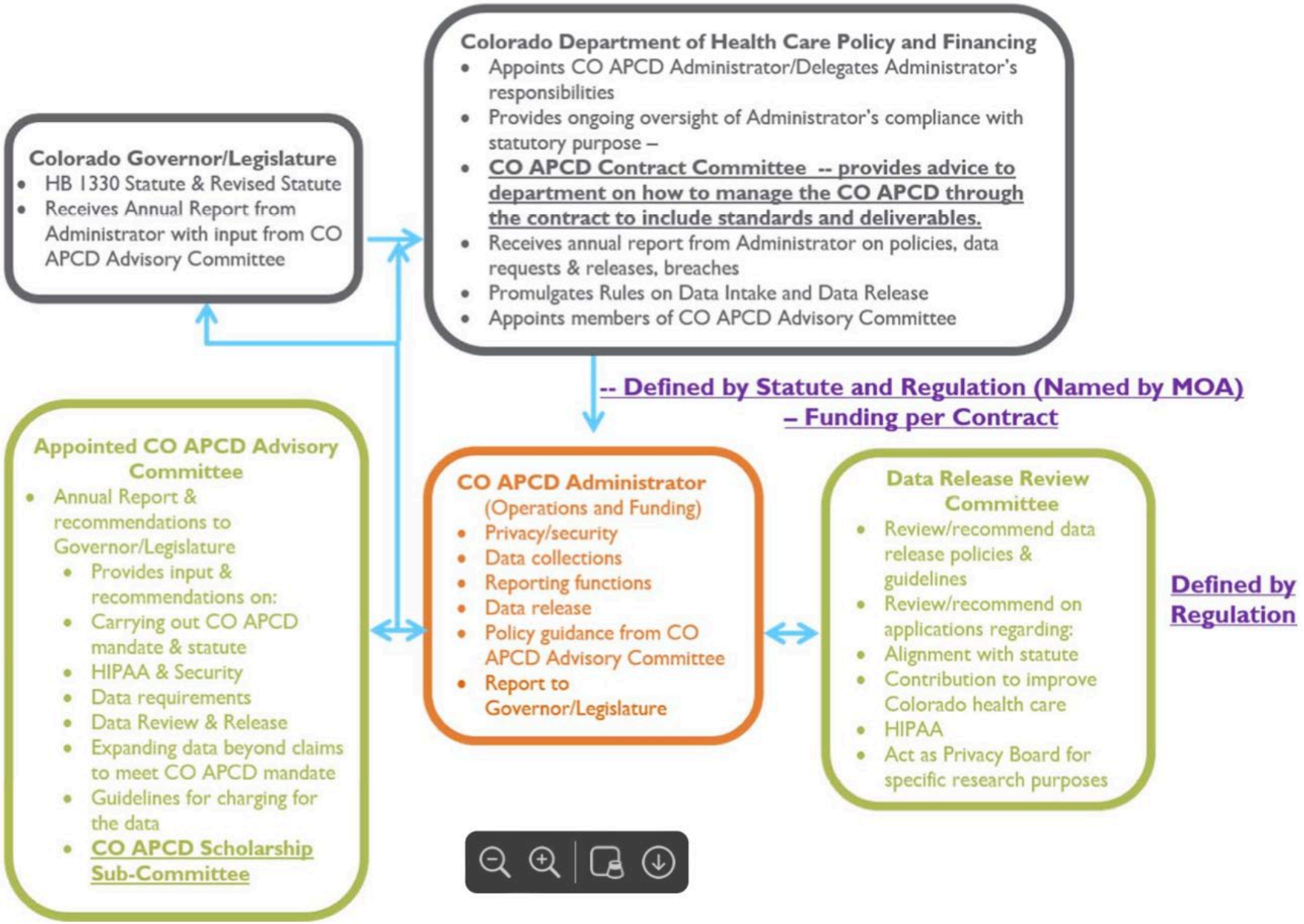
APCD do not have the authority to regulate or cap prices

- Some states (Montana, Oregon, and Washington) do cap prices, but those programs were enacted by state legislatures, not APCDs. APCDs only provide data and information that can inform policymakers
- APCDs also have comprehensive Data Governance Requirements that govern use of the data

Data Governance Example: Colorado

Most states require public disclosure of APCD data uses while offering stakeholders equal opportunity to make approved use of the data

APCD administrators rely on advisory bodies to help determine appropriate data uses that may advance a data requester's interests while also improving the functioning of the health care system or market



APCD Myths and Misunderstandings

Myth number 4: APCDs violate patient privacy and put patient data at risk of a data breach

APCDs follow rigorous data protections

- APCDs comply with Health Information Portability and Accountability Act (HIPAA) and HITECH act, National Institute of Standards and Technology (NIST), and other federal and state regulations
- Data is encrypted, and submissions are sent over encrypted connections
- Personal Identifiers are removed and replaced with encrypted identifiers not linked to any other source
- Other identifying information is aggregated such as age, zip codes, small cell data suppression
- **Data release follows data use agreements generated from the data governance process**

APCD Myths and Misunderstandings

Myth number 5: APCDs report inaccurate data and do not give submitting organizations opportunity to correct errors

APCDs use standard data formats, the APCD Common Data Layout

- The All-Payer Claims Database Common Data Layout (APCD-CDL™) helps harmonize the claims collection effort across states, increase accuracy, and reduce the burden of data submission
- These efforts improve efficiency, reduce administrative costs and improve accuracy in claims data collection
- Data submissions follow a prescribed process that includes checks, validation, and testing. Submitting organizations usually help validate accuracy of data submissions

The Elements of Good APCD Legislation

Purpose

- Understand health care costs and utilization trends among treatment settings, providers, and modalities
- Inform state health care planning and targeted population health initiatives
- Support research in the areas of health care cost, quality, and accessibility
- Evaluate the effectiveness of health care programs and services to improve patient outcomes
- Improve the accessibility, adequacy, and affordability of health care through the review and dissemination of data

Scope

- Require all state-regulated payers to participate with an opt-in for self-insured and ERISA-governed plans
- Define the information that will be collected, identify permitted uses and general reporting requirements

Governing Body & Oversight

- Designate a qualified party to implement, operate, and maintain the APCD
- Establish rule-making authority associated with the development of the APCD
- Create an APCD Advisory Council consisting of stakeholders, including consumers, hospitals, insurers, researchers, etc.
- Establish a uniform file format and data use agreements

Privacy & Confidentiality

- Comply with Health Information Portability and Accountability Act (HIPAA) and HITECH act, National Institute of Standards and Technology (NIST), and other federal and state regulations

Funding

- Create a sustainable funding model based primarily on federal funding, grants, donations, and user fees

Current State to Future State

Current	Future
•Uncoordinated, fragmented delivery systems with highly variable quality •Unsupportive of patients and physicians •Unsustainable costs rising at twice the inflation rate	•Affordable •Accessible to care and to information •Seamless and coordinated •High-quality – timely, equitable, and safe •Person- and family-centered •Supportive of clinicians

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