Total Cost of Care Measurement and All-Payer Claims Databases

Delaware Health Care Spending Benchmark Summit

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Background

- Delaware has high spending relative to other states and to its levels of clinical quality
- Through DHIN, DE is building upon its clinical data infrastructure to add claims data (APCD)
- There is a strategic desire to incorporate total cost of care (TCOC) benchmarking into APCDs
- Need to "Avoid building yesterday's APCD" and ensure it will meet likely future needs

All Payer Claims Database

- An aggregation of large data files – including member eligibility, medical & pharmacy claims, and providers – compiled from multiple health benefits payers
- First statewide APCD in Maryland in 1995
- First modern APCD in Maine in 2003
- Allows diverse and extensive examination of health and health care

Why an APCD?

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- Public Health
  - Disease incidence and prevalence
- Performance improvement
  - Transparent reporting of provider and payer results
  - Data may be used by providers to drive their QI efforts
- Health policy
  - Health spending by location and patient mix
  - Treatment choices and variation in treatments by region, by gender, by type of insurance, by provider
  - What are our cost drivers?
- Consumer choice
  - Which providers are better/worse in quality and cost?
  - Where should I be treated?
- Academic research
  - Policy and clinical research

Why an APCD?

- Benchmarking, including total cost of care

Examples

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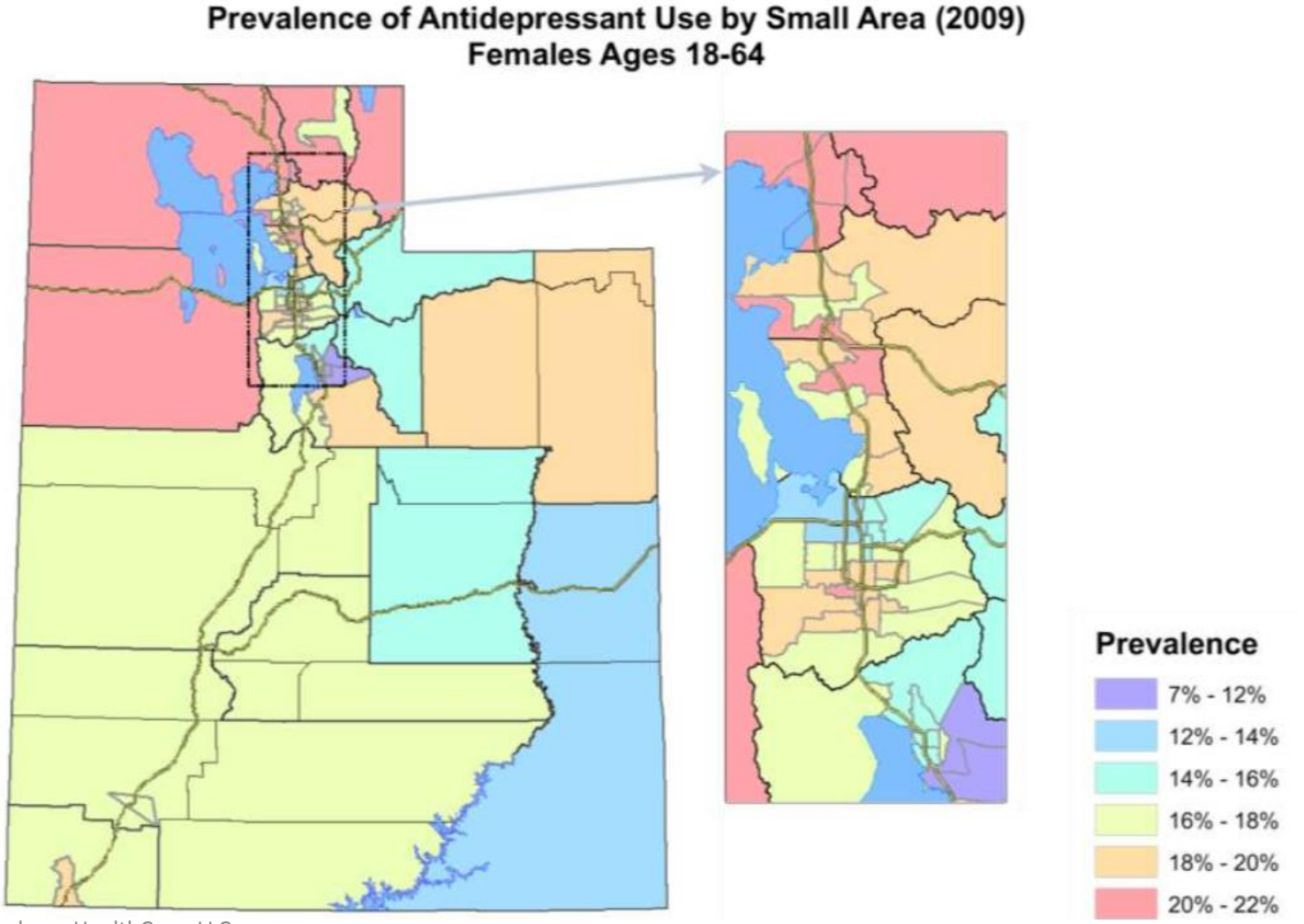
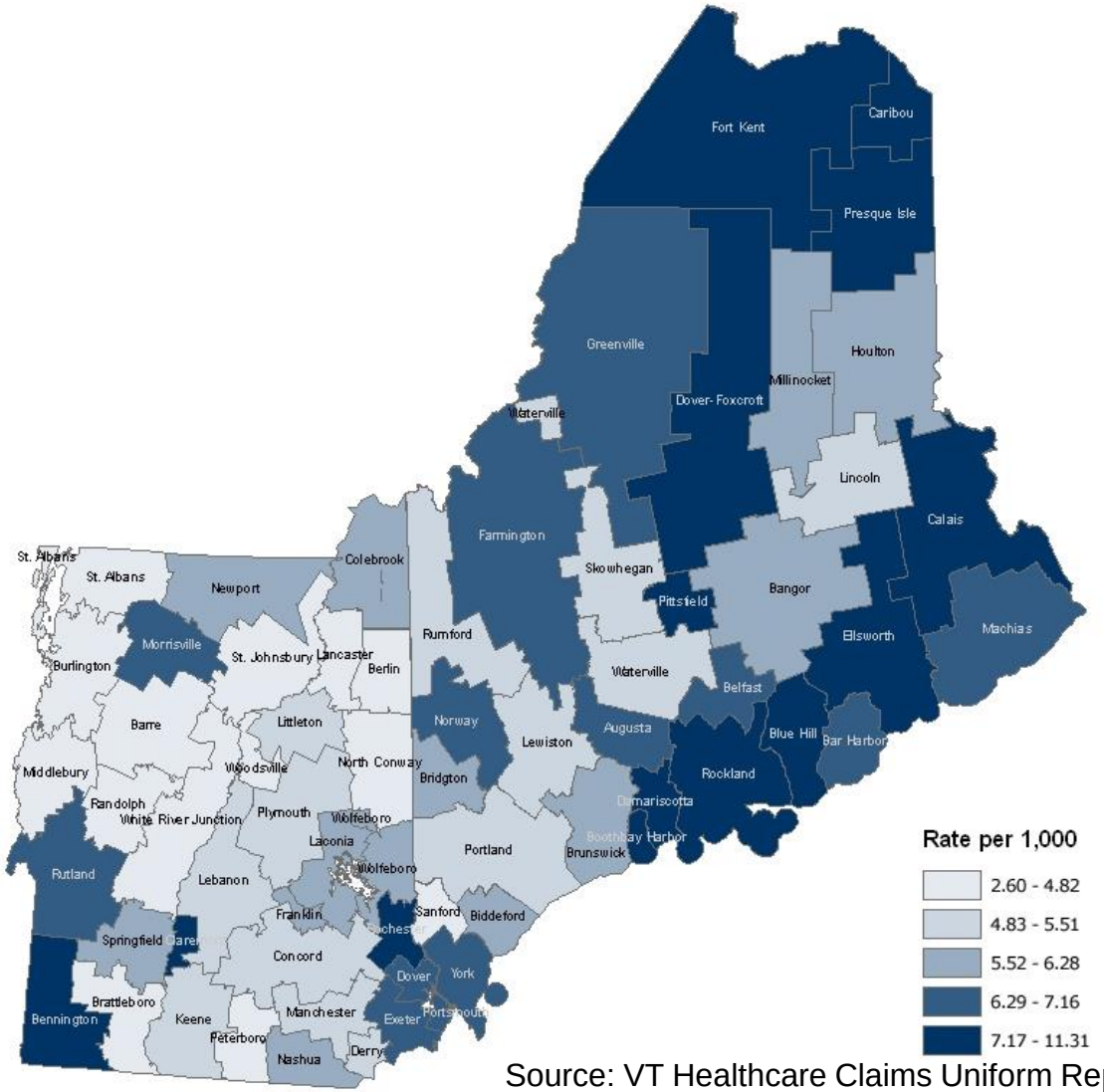
Anti-Depressant Use



Source: Utah Department of Health

30-Day Readmission Rates



Source: VT Healthcare Claims Uniform Reporting & Evaluation System

Cost Transparency

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Sunday, Janu

- Pricing of Health Care Services
  - A Deeper Explanation
- Health Costs for Insured Patients
- Health Costs for Uninsured Patients

Detailed estimates for MRI - Knee (outpatient)

Procedure: MRI - Knee (outpatient)
Insurance Plan: CIGNA, Health Maintenance Organization (HMO)
Within: 1000 miles of 02459
Deductible and Coinsurance Amount: $100.00 / 0%

Lead Provider Name	Estimate of What you Will Pay	Estimate of What Insurance Will Pay	Estimate of Combined Payments	Precision of the Cost Estimate	Typical Patient Complexity	Contact Info
DERRY IMAGING CENTER	$100	$896	$996	LOW	LOW	DERRY IMAGING CENTER 603.537.1363
CATHOLIC MEDICAL CENTER	$100	$1407	$1507	HIGH	MEDIUM	CATHOLIC MEDICAL CENTER 800.437.9666
CHESHIRE MEDICAL CENTER	$100	$1465	$1565	HIGH	MEDIUM	CHESHIRE MEDICAL CENTER 603.354.5400
SOUTHERN NH MEDICAL CENTER	$100	$1590	$1690	LOW	HIGH	SOUTHERN NH MEDICAL CENTER 603.577.2000
FRISBIE MEMORIAL HOSPITAL	$100	$1727	$1827	HIGH	HIGH	FRISBIE MEMORIAL HOSPITAL
DARTMOUTH HITCHCOCK - LEBANON	$100	$1946	$2046	LOW	MEDIUM	DARTMOUTH HITCHCOCK - LEBANON 603.650.5000
MARY HITCHCOCK MEMORIAL HOSPITAL	$100	$1946	$2046	HIGH	MEDIUM	MARY HITCHCOCK MEMORIAL HOSPITAL 603.650.5000
MEMORIAL HOSPITAL	$100	$1970	$2070	MEDIUM	LOW	MEMORIAL HOSPITAL 603.356.5461
WENTWORTH DOUGLASS HOSPITAL	$100	$1977	$2077	MEDIUM	VERY HIGH	WENTWORTH DOUGLASS HOSPITAL 603.742.5252
PORTSMOUTH REGIONAL HOSPITAL - HCA AFFIL	$100	$2242	$2342	HIGH	LOW	PORTSMOUTH REGIONAL HOSPITAL - HCA AFFIL 603.436.5110

Lead Provider This is the single entity that all health care procedure costs are assigned to in HealthCost. Even when separate payments are made to a physician and a hospital, the estimated payment amount is the combined total amount paid. When a Lead Provider is not listed in the results, we do not have sufficient data to calculate an estimate.

Estimate of What You Will Pay – This figure represents out of pocket payments you may be required to pay based upon your health coverage, your deductible, and your coinsurance. Deductibles and co-insurance are paid after the service is provided.

Estimate of What Insurance Will Pay – This figure represents the payment made by your insurance company to the health care provider.

Links to Other Data

- Quality – link cost and practice patterns to additional quality measures
  - e.g.,CMS, state quality reporting, regional collaboratives
- Vital statistics – to assess mortality rates
- Hospital Discharge Datasets – for additional data points
  - e.g., POA indicator
- Health Information Exchanges – prepare the way for integration of claims and EMR data

Strategic Approach to APCD

- Begin at the end: Create a vision for APCD data reporting
- Focus on principles and guidelines to allow downstream flexibility
- Leverage stakeholder engagement
- Collaborate with in-state HIE efforts

Limitations of APCDs

- Based on claims data
  - Timeliness
  - Completeness of coding
  - Handling alternative payment arrangements/settlements
- Cost of implementation and operation
  - Small (0.01%) share of health spending, but larger share of state budget
  - Lack of standard revenue model
- Privacy
  - Variable limits on access to data
- Comparability between states
  - Harmonization will improve comparability

Alternative Payment Methods (APM)

- Non-FFS
- Quality and Financial Performance Incentives
  - P4P, Payment Penalties, Shared Savings, Shared Risk
- Fixed Payments
  - Capitation, Limited Budget, Bundled/Episode-Based

The Challenges Oregon Faced

- Increasingly, OR payers spending more of their healthcare dollars on APM arrangements, but no centralized collection of this data

- Legislative Interest in APM Data:
  - APCD is meant to track the utilization, uptake, and comparative effectiveness of various payment methods (HB2009)
  - OHA is tasked with collecting data that enhances health payment reform and allows for reporting methods that are not claims-based (Chapter 389)
  - Reporting on the percentage of medical spending allocated to primary care each year (SB 231 and HB4017)

- However, APM payments are unlike other APCD data
  - Many are processed on separate platforms, outside of the claims system
  - Many are administered as annual bonus payments or contractual adjustments

OHA's Planning Process

Planning began in October 2015

- Identify and Research Mechanisms for Data Collection
  1. Using Data Already Collected by State (i.e. financial filings)
  2. Collecting Data Under Umbrella of APCD
     - Collecting as part of already existing APCD files
     - Collecting as separate file
- Confirm Authority to Collect Data under Possible Mechanisms
- Consider Cost and Complexity of New Data Stream
- Convene Stakeholders to Discuss/Establish Specific Use Cases
- Identify and Learn From Other States Collecting APM Data
  - Cannot be copy/paste!

Lessons Learned

- Not all payers have same definition of APM categories
- APM contracts have different performance periods –> think about who/how you will prorate this data
- Very difficult to flag claims-based payments captured in typical APCD files as being part of APM
- APM payments are often made to financial parent or holding company, not individual providers
- Some APM arrangements are tied to enrollment and others are not, making PMPM calculations difficult
- Work closely with your data manager to create specifications and validations!

Lessons Learned (Cont.)

- Make Sure You Understand the APM Data Source vs. the APCD Claims Data Source
  - Many payers can only report APM data for policies *sold* in the State (i.e. SITUS)
  - Many APCD's collect claims data for individuals *residing* in the state

This means that a Washington resident working in Oregon will not be represented in APCD Claims Data, but can be represented in APM data

Where Oregon Landed

- Separate APM file submitted annually

(first submission is 9/30/17 - 2yrs after planning began!)

- APM file will never be combined with claims-based APCD data
- APM file to capture all payments made to every billing provider/organization under plans SITUSED in Oregon
- Payments parsed out by Line of Business, Payment Arrangement Category (including FFS), primary care vs. non-primary care

What Will the Data Be Used For

- Understanding trends in APM adoption
  - Which APM arrangements are the most popular by LOB?
  - Is APM adoption increasing over time?
  - Where are APM providers located?
  - What portion of healthcare dollars go towards APM?
- What is the average PMPM spending for member-based APM arrangements (i.e. capitation, integrated delivery system)?
- What portion of healthcare dollars goes to primary care?

On the Horizon

- Validate data through payer feedback loop
- Consider aligning APM categories and definitions with HCP-LAN (categories 1-4)
- Revisit incorporation of additional APM measures with Technical Advisory Group to better understand value of APM's and whether they are driving change
- Consider whether APM file can supplant other filings to State

HCP LAN
Health Care Payment Learning & Action Network

Discussion