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# All Payer All Claims Database Overview for Technical Advisory Group

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July 29, 2014



# Presentation Goals

- Overview of
  - APAC data collected
  - Collection and data processing
  - Current analytic tools

# Background:

- APAC Authorized in HB 2009 to
  - Determine the maximum capacity and distribution of existing resources allocated to health care.
  - Identify the demands for health care.
  - Evaluate the effectiveness of intervention programs in improving health outcomes.
  - Compare the costs and effectiveness of various treatment settings and approaches.
  - Provide information to consumers and purchasers of health care.
  - Evaluate health disparities, including but not limited to disparities related to race and ethnicity.

# Who Submits

# APAC

OHA,  
Oregon  
Health  
Plan

CMS,  
Medicare  
FFS

Carriers

Pharmacy  
Benefit  
Managers

Third Party  
Administrators

>5,000 Covered Lives in Oregon

# Who Does Not Submit to APAC

- Federal self-insured programs
  - Tricare
  - Indian Health Services
- Self-pay / uninsured
- Stand-alone vision coverage
- Stand-alone dental coverage
- Stop-loss only coverage
- Non-mandatory reporters (<5k covered lives)

# Medicare FFS – Collected but Restricted

- Will be included in APAC for research purposes, broadly defined
- Under current authority, only fully de-identified data can be used for reporting at the provider level
- Additional authority is possible under CMS's Qualified Entity program

# What is Submitted to APAC

- Claims files
  - Paid claims (medical, pharmacy)
  - Diagnoses
  - Procedures performed
  - Member financial responsibility (co-pay, coinsurance, deductible)
  - Billed, Paid, Allowed, Patient Paid, COB & other amounts
- Provider file
  - Provider identifiers
- Enrollment file
  - Health plan member information (name, health plan member id, DOB, gender, geography)

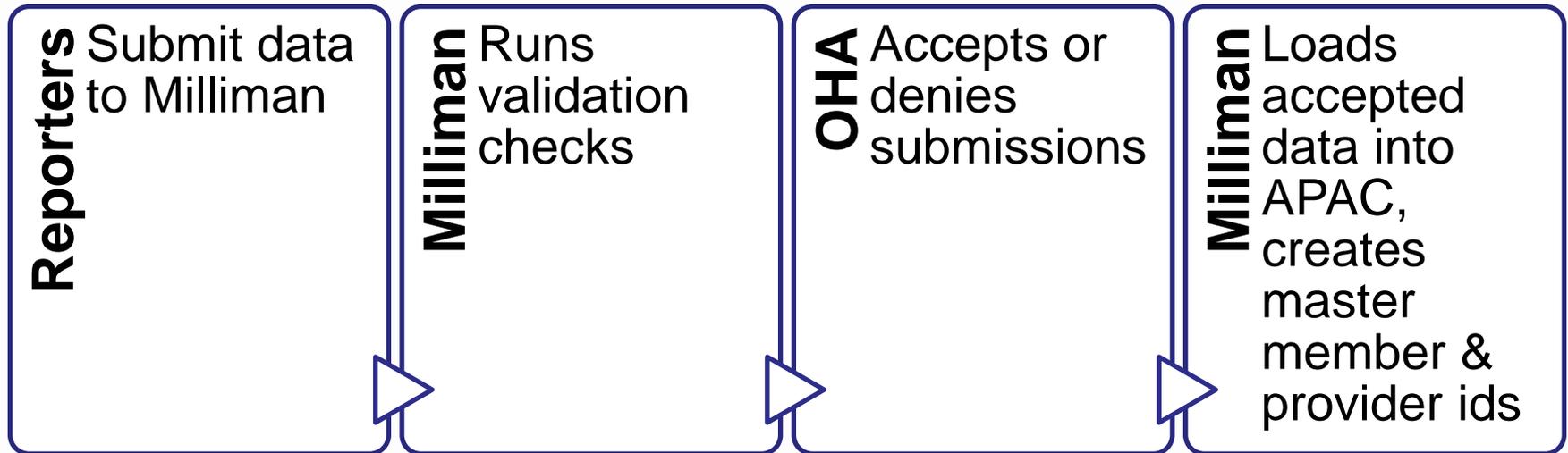
# What is currently not submitted to APAC

- Insurance market segment (individual, small group, large group, through Cover Oregon, etc.)
- Insurance product information (deductible, coinsurance requirements, actuarial value)
- Worker's compensation claims
- Substance abuse claims
- Bundled payments are a gray area

# APAC Does Not Capture Non-Claims Based Payments

- Capitation arrangements
- Back-end settlements
- Manufacturer rebates
- Case management fees
- Member incentives
- Pay for performance
- Payer or carrier administrative expenditures / net cost of private health insurance

# How is the data collected & processed



# Timing

- Claims may not appear in APAC for 6+ months
  - Service is incurred
  - Provider submits claim to carrier
  - Carrier adjudicates claim
  - Carrier reports claim to Milliman on a quarterly basis with a deadline of one month after the end of each calendar quarter
  - Milliman loads claim in to APAC (currently, ~1 month)

# Analytic supports

- Proprietary groupers
  - Episode Treatment Groups\*
  - Health Cost Guidelines grouper (category of service)
  - 3M's APR-DRGs
  - Episode Risk Groups\*
- Milliman's Health Care Management Benchmarks
- CMS's Hierarchical Condition Categories Risk Scores
- Evidence-based Measures - HEDIS-like measures (not HEDIS certified)

\* - license via Milliman expected to expire