
All Payer All Claims Database Overview and Opportunities for Sustainable Health Expenditures Reporting and Analysis

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Presentation Goals

- Understanding of information & tools currently included & not included in APAC
- Understanding of opportunities to use APAC to understand health care cost drivers and promote sustainable health care expenditures
- Identification of next steps to develop APAC data collection, validation and analysis in collaboration with APAC Technical Advisory Group

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: DMAP, Carriers, PBMs, TPAs

APAC

DMAP

Carriers

Pharmacy
Benefit
Managers

Third Party
Administrators

CCOs

MCOs

OHP
FFS

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)
- Provider file
 - Provider identifiers
- Enrollment file
 - Health plan member information (name, health plan member id, DOB, gender, geography)

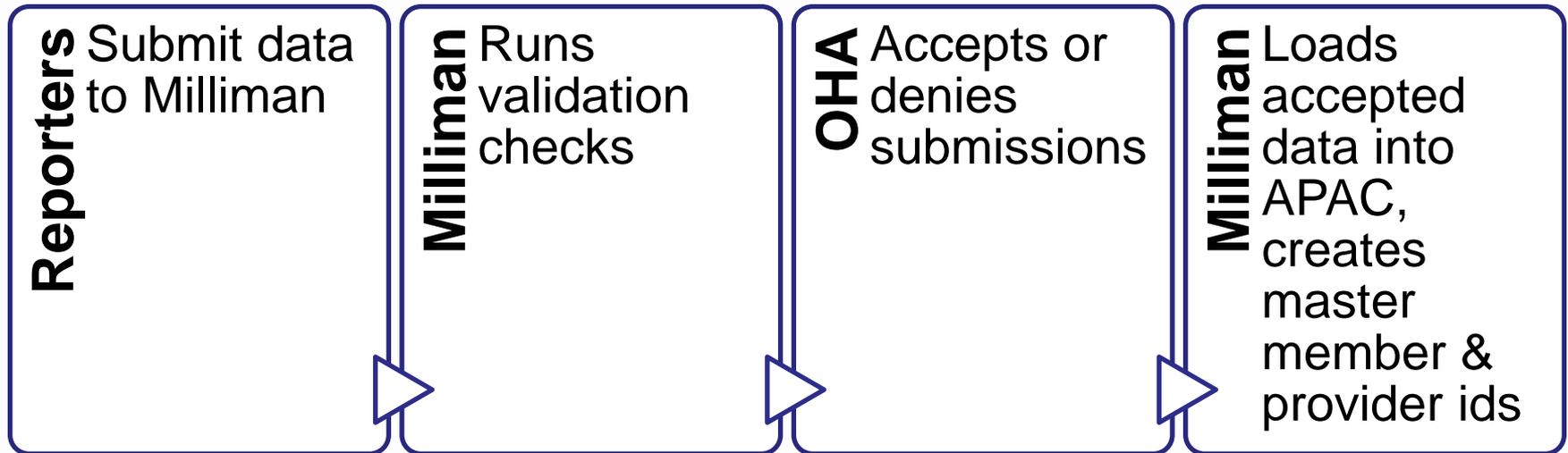
What is currently not submitted to APAC

- 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

Example Cost & Utilization Reporting from APAC

- Excerpt from June 2014 Oregon Health Policy Board Dashboard

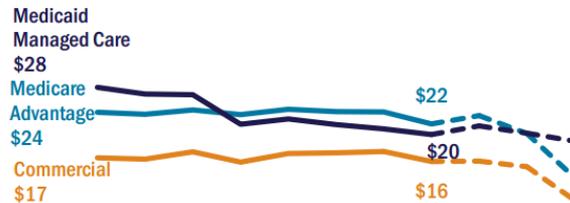
Cost & Utilization (pages 2-8)

Total* Expenditures Per Member Per Month (PMPM)



2011	2012	2013
Q1 Q2 Q3 Q4	Q1 Q2 Q3 Q4	Q1 Q2 Q3

Emergency Department Expenditures PMPM



2011	2012	2013
Q1 Q2 Q3 Q4	Q1 Q2 Q3 Q4	Q1 Q2 Q3

Primary Care Expenditures PMPM



2011	2012	2013
Q1 Q2 Q3 Q4	Q1 Q2 Q3 Q4	Q1 Q2 Q3

APAC Technical Advisory Group

- The purpose of the APAC Technical Advisory Group is to assure that all data reported meet the needs of stakeholders and that the processes involved in identifying, developing, and validating measures are appropriate and transparent, by advising OHA on:
 - Data sources, measure specification, and data validation processes required to produce accurate, reliable, and valid reports
 - Additional data elements necessary to address expanding needs and goals for APAC data

Other Potential Data Sources

- Hospital Discharge Data
 - Includes diagnosis and procedure information on each discharge from non-federal acute care hospitals in Oregon
 - Expenditure data is in terms of charges or billed amounts rather than paid amounts or costs
- Audited Hospital Financials
 - Includes hospital-level information on net patient revenue and other operating revenue
 - Reported on the basis of hospitals' fiscal years, which vary
- Hospital Community Benefit Data
 - Includes charity care and other community benefit expenditures in terms of cost to hospitals (as opposed to charges)
- Individual & small group market rate filings
- Various Medicaid, Medicare Advantage and self-insured financial reports