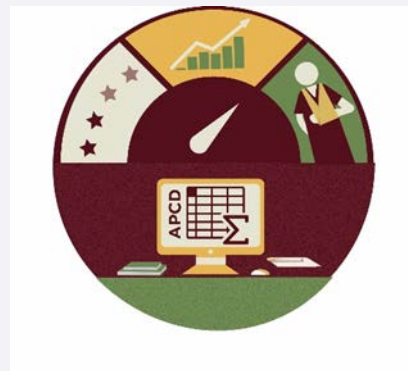


All Payer Claims Database

Adam Zolotor, MD, DrPH
President & CEO



April 23, 2018

Overview

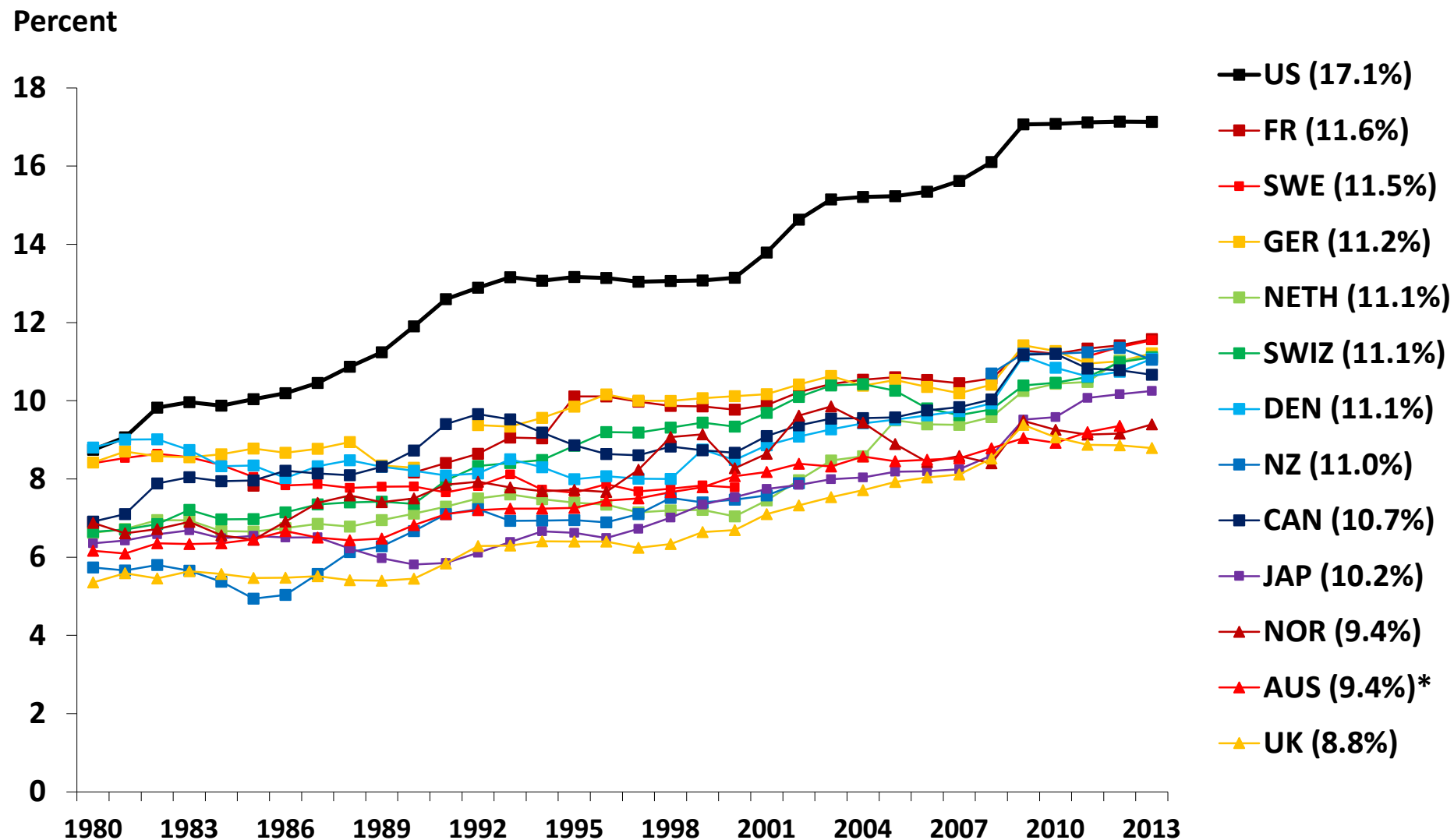
- 5 Meetings from August-January
- 43 task force member from various stakeholder groups including DHHS, DIT, NCGA, NCHA, NCDS, insurers, consumers, behavioral health, academia, and others.
- 6 steering committee members
- Partners include:
 - The Duke Endowment
 - Department of Health and Human Services
 - Institute for Emerging Issues



Task Force on All Payer Claims Database

- Focus on Triple Aim
- Cost of healthcare as % of GDP
- Tremendous variation in care, cost and quality
- Movement towards transparency
- Movement towards consumer directed spending and patient engagement

Exhibit 1. Health Care Spending as a Percentage of GDP, 1980–2013



* 2012.

Notes: GDP refers to gross domestic product. Dutch and Swiss data are for current spending only, and exclude spending on capital formation of health care providers.

Source: OECD Health Data 2015.

Exhibit 9. Select Population Health Outcomes and Risk Factors

	Life exp. at birth, 2013 ^a	Infant mortality, per 1,000 live births, 2013 ^a	Percent of pop. age 65+ with two or more chronic conditions, 2014 ^b	Obesity rate (BMI>30), 2013 ^{a,c}	Percent of pop. (age 15+) who are daily smokers, 2013 ^a	Percent of pop. age 65+
Australia	82.2	3.6	54	28.3 ^e	12.8	14.4
Canada	81.5 ^e	4.8 ^e	56	25.8	14.9	15.2
Denmark	80.4	3.5	—	14.2	17.0	17.8
France	82.3	3.6	43	14.5 ^d	24.1 ^d	17.7
Germany	80.9	3.3	49	23.6	20.9	21.1
Japan	83.4	2.1	—	3.7	19.3	25.1
Netherlands	81.4	3.8	46	11.8	18.5	16.8
New Zealand	81.4	5.2 ^e	37	30.6	15.5	14.2
Norway	81.8	2.4	43	10.0 ^d	15.0	15.6
Sweden	82.0	2.7	42	11.7	10.7	19.0
Switzerland	82.9	3.9	44	10.3 ^d	20.4 ^d	17.3
United Kingdom	81.1	3.8	33	24.9	20.0 ^d	17.1
United States	78.8	6.1 ^e	68	35.3 ^d	13.7	14.1
OECD median	81.2	3.5	—	28.3	18.9	17.0

^a Source: OECD Health Data 2015.

^b Includes: hypertension or high blood pressure, heart disease, diabetes, lung problems, mental health problems, cancer, and joint pain/arthritis. Source: Commonwealth Fund International Health Policy Survey of Older Adults, 2014.

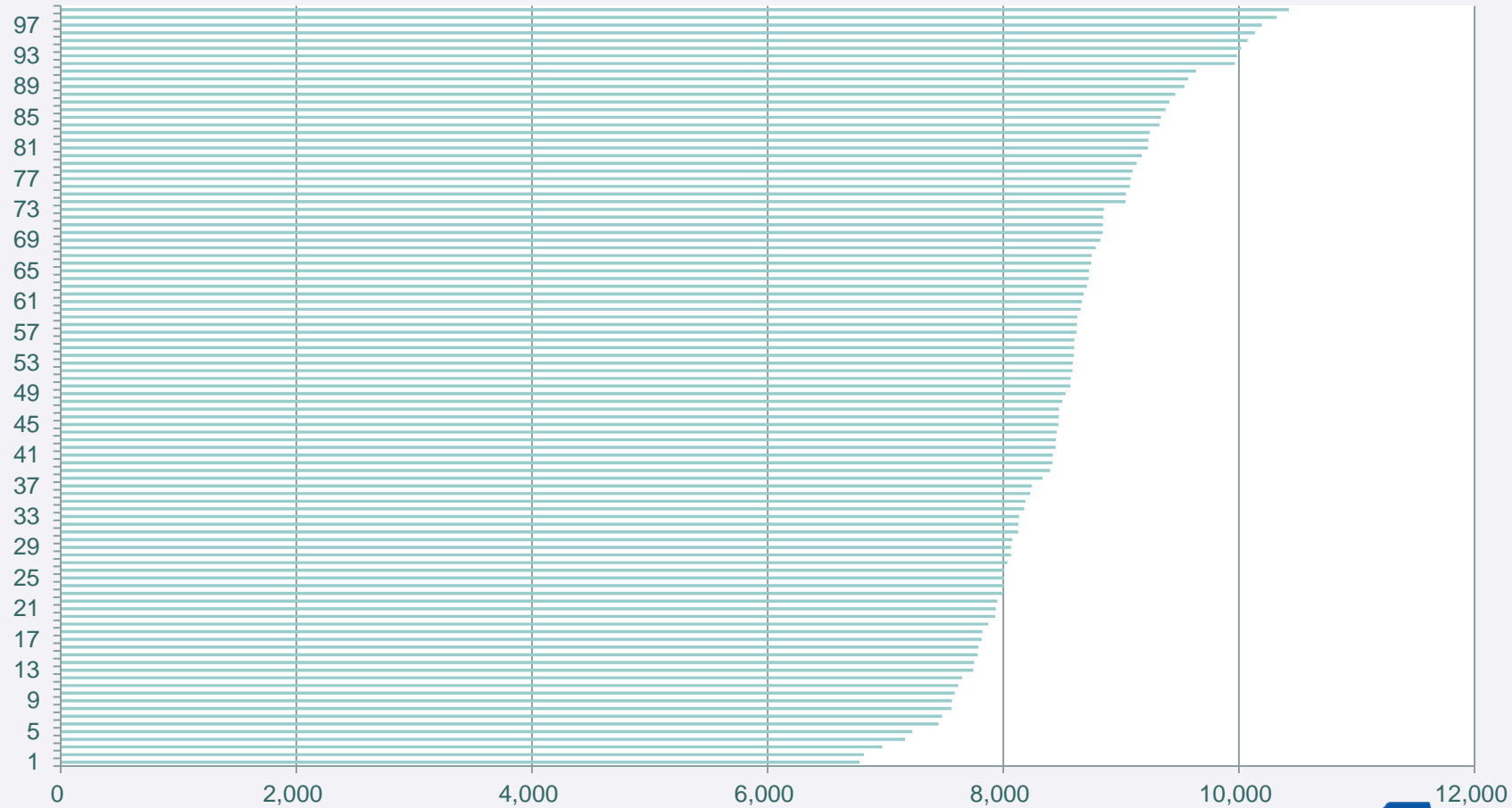
^c DEN, FR, NETH, NOR, SWE, and SWIZ based on self-reported data; all other countries based on measured data.

^d 2012. ^e 2011.

Uses of an APCD

- Public health surveillance
- Health system planning/QI
- Payer planning/QI
- Employer assessment of cost, comparison shopping
- Consumer directed query (at the level of the individual or consumer advocacy organization)
- Health services research

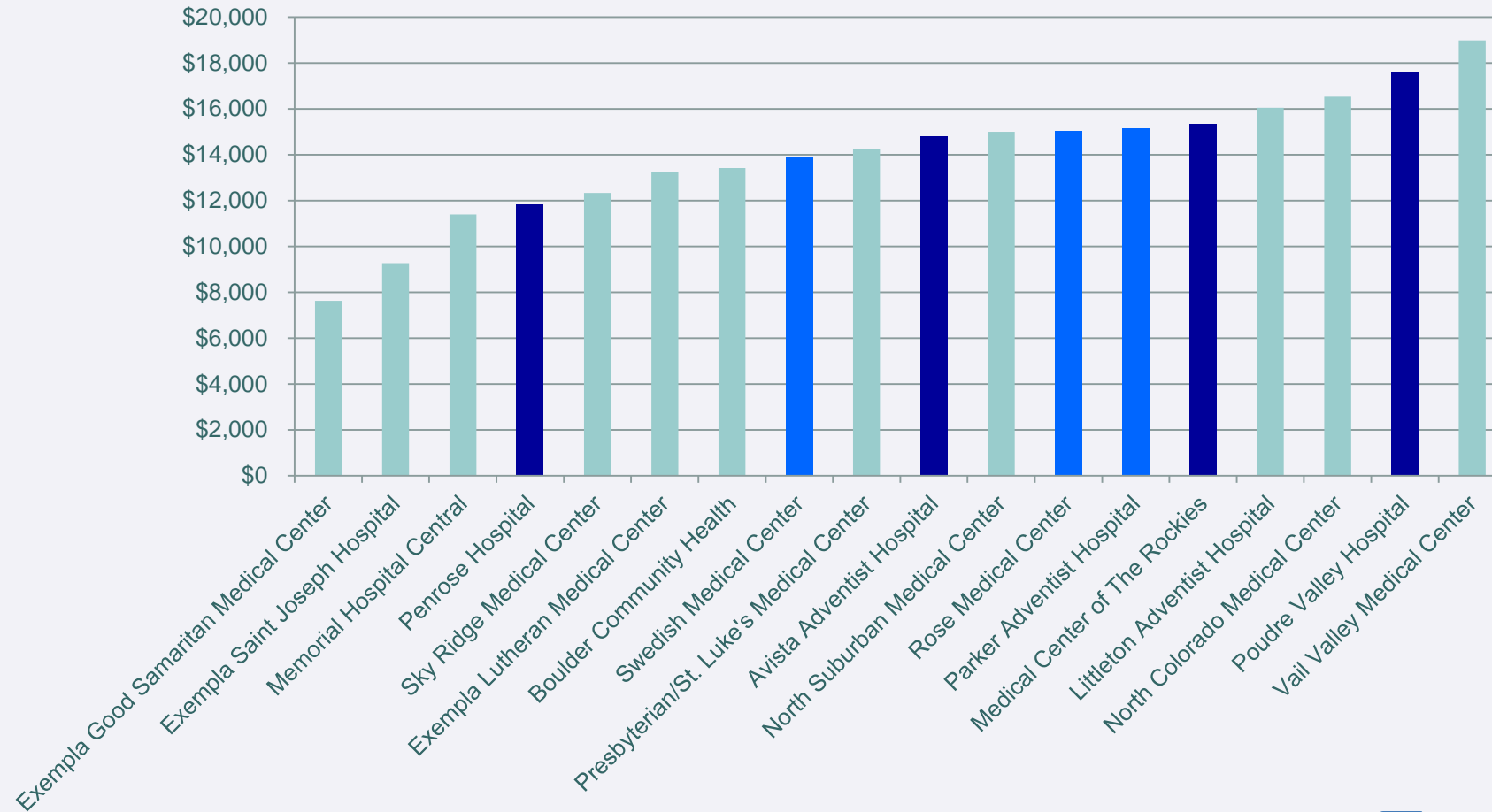
Variation in cost



Adjusted Cost per Medicare Enrollee by County, Dartmouth Atlas, 100 counties



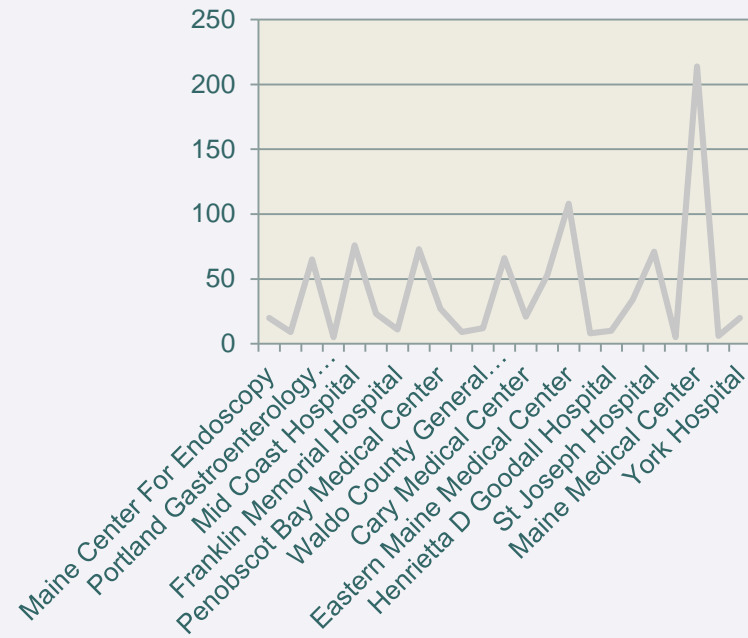
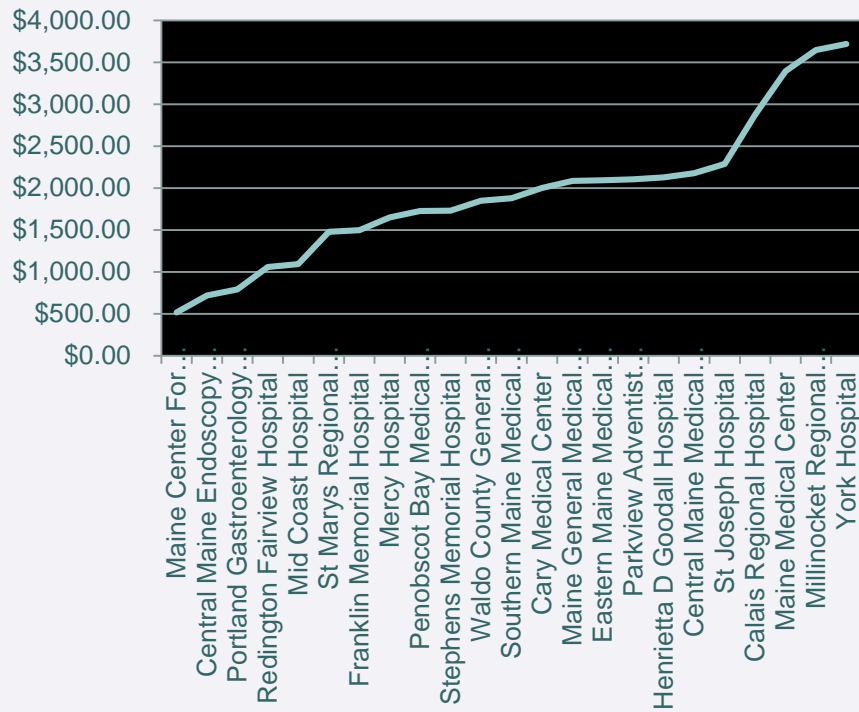
Colorado APCD Cesarean section cost and VTE



Rates of VTE Teal=average; Purple better; Blue worse (hospital overall)

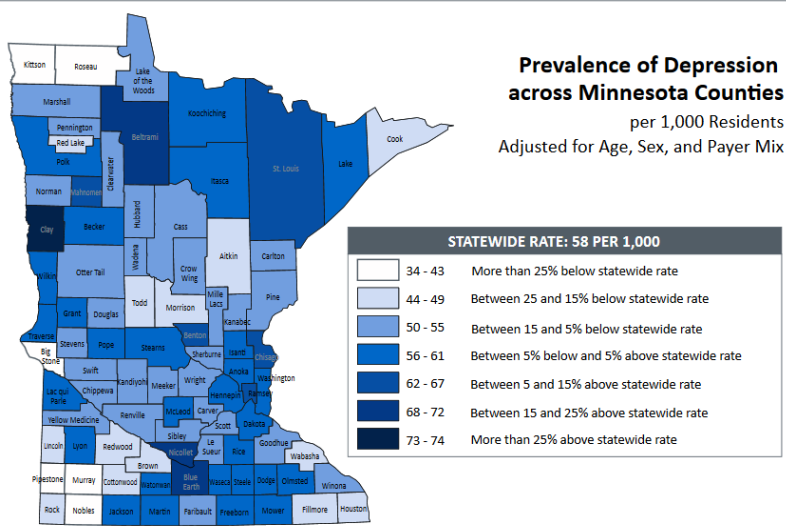


Maine APCD Total Cost and Volume Upper endoscopy



APCD

- 23 states have an APCD or are actively developing an APCD
- Include 'all claims', and depending on governance, inpatient, outpatient, behavioral health, pharmacy, dental. Special challenges: VA claims, pre-paid health plans, Medicare, and ERISA governed employer sponsored plans.



Top 10 Clinical Risk Groups (CRGs)

Table 1. Top 10 CRGs by percentage of the Utah APCD-covered population and associated cost, 2014

Clinical Risk Group (CRG)	APCD Population Count	Percentage of APCD Population	APCD Total Cost	Percentage of APCD Total Cost
Healthy and non-users	1,403,185	58.3%	\$750,871,875	9.0%
Hypertension	88,796	3.7%	\$238,638,745	2.9%
Multiple minor primary chronic diseases (PCDs)	61,811	2.6%	\$325,788,386	3.9%
Malignancy diagnosis without other significant illness	38,720	1.6%	\$61,389,082	0.7%
Diabetes and hypertension	32,778	1.4%	\$180,201,132	2.2%
Depression	31,865	1.3%	\$73,173,294	0.9%
One significant acute illness excluding ear, nose, and throat (ENT)	30,977	1.3%	\$65,016,800	0.8%
Two other moderate chronic diseases	30,513	1.3%	\$331,850,627	4.0%
Chronic thyroid disease	25,487	1.1%	\$50,110,900	0.6%
Diabetes	24,368	1.0%	\$130,786,347	1.6%
Total	1,768,500	73.6%	\$2,207,827,188	26.6%

Percent of Children With a Well-Child Visit to a Primary Care Practitioner by Plan Type, SFY2008

New Hampshire			
Age Group	Medicaid	SCHIP	NH CHIS Commercial
16-35 months	88.9%	95.4%	89.0%
3-6 years	69.9%	82.7%	77.7%
7-11 years	55.0%	63.0%	61.3%
12-18 years	50.4%	57.3%	55.4%
National Managed Care Plan Data*			
Age Group	Medicaid	Commercial	
3-6 years	65.3%	67.8%	
12-21 years	42.0%	41.8%	

Note: SCHIP does not cover children under the age of one. The SCHIP column is a combination of Medicaid and SCHIP for the 185-300% of federal poverty level group.

*2008 NCQA HEDIS reporting year on 2007 data.

Minnesota's APCD

- Minnesota developed their APCD in 2008, are currently using it to assess
 - Completed a study of chronic pain management procedures
 - Completed a study on potentially preventable health care events
 - Developing a chronic disease atlas
 - Pediatric health care use atlas
 - Analysis of prescription drug spending in Minnesota
 - Study of prescription use of opioid drugs for chronic pain
 - Looking into health care cost drivers to assess the factors that underlie health care spending growth

Charge to Task Force

- Is an APCD right for NC?
 - Current climate? Medicaid reform. Rapidly developing HIE.
- If yes:
 - Voluntary or involuntary?
 - Governance
 - Financing
 - Interface
 - Space cases

Recommendation 1

- **The North Carolina General Assembly should establish an All Payer Claims Database (APCD). The goal of the database is to improve the health of North Carolinians. Primary use cases include population health surveillance, research, and public policy analysis. However, the legislation, regulation, and design of the database should allow for flexibility for other uses if appropriate.**

Recommendation 2

- **The North Carolina General Assembly should create an APCD governing or advisory board that consists of health care stakeholders. The type of stakeholders to consider include providers, consumers, employers, payers, researchers, representative from NC FAST and the HIE. The governing board is responsible for identifying an organizational home, creating regulations surrounding submission and release, infrastructure and maintenance, identifying supplemental funding and other issues as they arise.**

Recommendation 4

- **The North Carolina General Assembly should appropriate recurring funding to support the North Carolina APCD. The North Carolina General Assembly and the North Carolina APCD governing board should explore supplemental funding from Medicaid funds, philanthropy, HITECH, and data use fees.**

Recommendation 5

- **The North Carolina APCD should be developed with the goal of leveraging other sources of health and human services data.**
 - Leverage other databases such as: Health Information Exchange, NC FAST, Carolina Data Warehouse for Health, etc.

Recommendation 7

- **The North Carolina APCD should collect all claims data. Proxy data on uninsured patients should be incorporated into the database in the future.**
 - **Include Medicare, Medicaid, State Employee Health Plan, private payers**
 - **Dental claims, medical claims, pharmacy claims, substance use claims, shadow claims claims**

For More Information

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