



TASK FORCE ON ALL-PAYER CLAIMS DATABASE

Thursday, September 22, 2016
North Carolina Institute of Medicine, Morrisville
10:00-3:00 pm

Attendees

Members: Jennifer Alviano, Dale Armstrong, Paige Bennett, Rob Burns, Chris Collins, Joe Cooper (co-chair), Adam Linker, Mark Massing, Dev Sangvai, Bernie Inskip, David Smith, Sam Clark, Stephanie McGarrah, Chris Mansfield, Lin Hollowell, Denyse Bayer (cc), John Freedman (cc), Kimberly Williams (cc), Matt Meyers (cc), Garlinda Taylor, Bob Rosenthal, Mona Moon, Sue West, Paige Bennett, Linwood Hollowell, Steve Cline, Chris Mansfield, Jay Chaudhuri, Mike Dulin, Dee Jones

Steering Committee and NCIOM Staff: Zach Ambrose, Mark Bell, Lauren Benbow, Anne Foglia, Sarah Langer Hall, Darryl Meeks, Anna Waller, Walker Wilson, Berkeley Yorkery, Adam Zolotor

Guests: Jennifer Anderson, Tara Britt, Ran Tan, Abby Emanuelson, John Freedman (cc), Kimberly Williams (cc), Denyse Bayer (cc), Matt Meyers (cc), Linda Green (cc), Ashok Krishnamurthy

Note: We experienced some difficulties making audio available to our webinar participants during this meeting. We apologize for the inconvenience and will be sure to sort out these issues prior to the October meeting.

WELCOME AND INTRODUCTIONS

Joseph Cooper
Chief Information Officer
Information Technology Division
North Carolina Department of Health and Human Services

Mr. Cooper called the meeting to order, reviewed the agenda and the charge of the task force, and introduced the first presentation.

APCDs IN OTHER STATES: OVERVIEW

Lauren Benbow, JD
Project Director
North Carolina Institute of Medicine

The presentation was a review of APCDs in other states. It included a map of states with APCDs and illustrated that most states have an APCD, are implementing an APCD, or are 'strongly interested' in an APCD. The presentation looked closely at Delaware and Florida, which both passed new legislation in 2016 to implement an APCD. Overall, the presentation demonstrated

that there is great variety in APCDs and each APCD is unique. There was a discussion regarding funding sources for APCD: some states have a Medicaid match, some include grant funding, while other states have funding from general appropriations. There is a large range in the expenses of an APCD. The APCDs are mostly housed within a state government agency, although a few states have APCDs in non-profits. Most of the APCDs are mandatory, meaning that the insurance companies have to submit their data to the database. All of the APCDs collect medical data, all collect the state Medicaid data, some collect dental, most collect Medicare data, none of the states collect military claims. The group also discussed behavioral health data and uninsured claims data.

Ms. Benbow's presentation is available here: <http://www.nciom.org/wp-content/uploads/2016/07/APCD-9-22-Presentation.pdf>.

Questions and Discussion:

- Have any of the state legislatures asked for program evaluation to determine ROI yet?
- Question on vendors, how many companies are doing this? What are they like? Huge variety in descriptions of APCDs, a range of options available regarding vendor and style, relative strengths and weaknesses of vendors, need to understand the nuances, every state has a slightly different set of priorities, and thus has different APCDs
- RTI is the evaluator for the SIM initiative, will be getting APCD data from Oregon, MN, Maine and Vermont, may get a sense of the pros/cons of each of their APCDs, Sue West is leading the Arkansas team, not-for-profit developing their APCD,
- Who's capturing the shadow claims in Maine from all the health systems; BC of Maine issued pseudo id cards to the uninsured and nothing is paid but the claims are processed through BC; Chris Collins has had this conversation with NC TraCS about this type of infrastructure
- What are the HIPAA concerns about 3rd party claims being identified and sent to a 3rd party database? There are always concerns, when it's mandated by state law, the state is on the hook, this is a primary reason many employers have stopped submitting ERISA data because once it's voluntary it changes the nature of the HIPPA question. Even with de-identified data there are concerns—how many 80 year males are in a particular small town? Virginia has data use and business associate agreements that help to shift the HIPAA liability.
- Uncompensated care? Safety net providers would have an interest in getting that information.
- Difference between non-payer and uninsured but paid. Non-traditional payer, where is that data being collected?
- What goals and uses can be achieved with voluntary vs. mandatory APCDs? –the difference is completeness of data (rare diseases or epidemiological tracking want 100%, but can learn a lot about cost/quality/value with 60%)

APCDs & ERISA, GOBEILLE v. LIBERTY MUTUAL

David Smith

Vice President, EbenConcepts

*Member, Past President
North Carolina Association of Health Underwriters*

Mr. Smith provided an overview of ERISA and the *Gobeille v. Liberty Mutual* case. Mr. Smith explained that ERISA is a federal statute to regulate retirement and welfare plans. The law applies to private sector employers and employee organizations like unions and to fully insured and self-funded plans. The only exceptions are government entities, churches, and a limited farm exception. It was designed to create a federal veto over state regulation of these health plans. Mr. Smith explained that ERISA preemption is a highly litigated issue at the Supreme Court. The Court has interpreted the provision very broadly, regulations of plans have been preempted and do not apply to self-funded plans. There is an exception to preemption-savings clause that allows states to continue to regulate insurance companies and products.

Mr. Smith explained the *Gobeille v. Liberty Mutual* case and each party's argument. Vermont argued that the APCD law was an indirect burden, shouldn't be preempted by ERISA, was not unduly burdensome, and was not an insurance law but a health care law. Liberty Mutual argued that the Vermont law depended on the administration for its effectiveness and was therefore within the scope of preemption. Liberty Mutual also argued that this was a regulatory burden on multistate plans. The Court concluded that ERISA is meant to prevent states from imposing novel, inconsistent and burdensome reporting requirements on insurance plans, and if multiple jurisdictions were to issue differing or parallel regulations it could create wasteful administrative costs.

In conclusion, most self-funded plans through third party administrators have stopped providing information to the state APCDs. The attention has shifted to the US Department of Labor, which could develop uniform rules.

This case is important for North Carolina APCD development because a large portion of the NC market is self-funded. 30% paid claims come from self-funded plans; 50-60% of privately paid claims. Uniform collection and distribution would be hugely beneficial to insurers in order to decrease their administrative burden in claims submission.

Mr. Smith's presentation can be found here: <http://www.nciom.org/wp-content/uploads/2016/07/ERISA-Gobielle.pdf>.

NORTH CAROLINA HEALTH INFORMATION EXCHANGE

Darryl Meeks, CDP, ITIL, PMP

Executive Director

North Carolina Health Information Exchange Authority

Mr. Meeks provided an overview of the North Carolina Health Information Exchange Authority, the goals of a Health Information Exchange, and the North Carolina statutes governing this work. Mr. Meeks discussed the data elements currently available, including encounters, allergies, medications, immunizations, problems, procedures, and results. As of September 20th, Mr.

Meeks said they have 109 live data connections. By the end of the year the NC HIE should have between 150-200 live data connections.

Mr. Meek's presentation is available here: <http://www.nciom.org/wp-content/uploads/2016/07/NC-Health-Information-Exchange-Authority.pdf>.

Questions and Discussion:

- How does HIE data connect with APCD data? There's a clinical value and cost transparency value in marrying this data.
- Master Patient Index? Yes. The North Carolina Health Information Exchange Authority is further developing/expanding it now.

CAROLINA DATA WAREHOUSE FOR HEALTH

Emily Pfaff

IT Director, NC TraCS

Operational Lead, Carolina Data Warehouse for Health

Ms. Pfaff discussed the Carolina Data Warehouse for Health, which collects data from 8 hospitals and over 200 practices. The TraCS database is used for research purposes, and UNC health care uses it for it for operations and quality improvement. There is data on approximately 4.8 Million unique patients/900,000 continuous patients, going back to 2004. The data model includes everything in the electronic health record. The database recently embarked on data sharing projects. For instance, the Clinical Data Research Network is a federated data model where different institutional databases use a common data model which can be queried simultaneously without having to send data.

The Clinical Data Research Network can be used to query large swaths of patients while the Health Information Exchange is useful for real-time clinical care, because it pulls data about a particular patient by their provider.

Ms. Pfaff explained that the claims information from an All Payer Claims Database would have additive value to a clinical data research network rather than a replacement. She discussed that because we operate in integrated delivery systems that are open, (patients can go wherever they want to receive care and may attend practices not affiliated with academic health systems) the claims data will be more comprehensive. The best way to see a patient's full spectrum of care if that patient is going to multiple institutions is to blend claims and electronic health record data.

Ms. Pfaff's presentation is available here: <http://www.nciom.org/wp-content/uploads/2016/07/Data-Driven-Health-and-Clinical-Research.pdf>.

Questions and Discussion:

- Is post adjudicated needed, or can providers share without payers share? Ms. Pfaff explained that providers don't know if a patient picked up their medications. Community

practices don't generally have the IT resources to join a CDRN, so are only represented in the APCD.

- What are the limitations on how this information can be shared? Ms. Pfaff explained that the governance process is mature and efficient. The requestor must be a UNC collaborator and IRB approval is required to share UNC data. They have data use agreement templates for other institutions.

SMALL DISCUSSION: USE CASES

The Task Force broke into four small groups to discuss the various use cases for an APCD. The four groups were provider, consumer/business, research and payer. The notes below reflect the feedback from each small group discussion.

- **Provider:**
 - The provider group felt that clinical data is more important to them unless other incentives challenge providers to use/analyze other types of data. The hospital and physicians offices are more motivated than other to understand claims data because hospital needs to understand the total cost of care, particularly in a value-based care environment and need to understand how they compare in the marketplace. The challenges of an APCD and the data is that the data must be presented in context, they don't want the cost pressure to decrease staff wages. It is also important to present quality along with cost.
- **Public Health:**
 - Public Health discussed the value of an APCD in terms of access, health services planning, rural community challenges, surveillance, and making smarter decisions about focusing scarce resources. The challenges of an APCD from a public health point of view were the time lag, lack of substance use data, the percentage of high risk populations that are not being tracked, and the need to link clinical and claims data for maximum value.
- **Insurers:**
 - Insurers discussed challenges in an APCD, including that in many states they want to gather the data from the insurer and then sell it back, that it is expensive to submit data to an APCD, there are concerns about insurance competition and they have found that consumers are not using the price transparency tools provided by them, most patients find their providers and care through referrals. In addition, the insured patients are concerned about what the cost is to them under their plan, not what the average cost is. The insurer group discussed how to make an APCD as little of a burden as possible. The solutions were to work collaboratively with payers, set realistic timelines, discuss the pros & cons with national vendors and to use a common data layout
- **Consumers:**
 - The consumer group discussed the benefits of transparency in cost data, the value in comparing quality and cost, that the APCD could be a resource when negotiating with providers. For employers, the APCD could allow them to understand cost driver, compare negotiated plans, and could enhance employer quality collaborative and employee wellness initiatives. The challenges of an

APCD from a consumer perspective included concerns about consumer interpretation of the information.

NEXT STEPS

The next meeting will be held Thursday, October 13, 2016.

The November 4th Task Force meeting is cancelled.

There is a new Task Force meeting added for January 26th.

The next steps of the task force are to decide on the goals of an APCD in North Carolina.