California All-Payer Claims Database
Summary Memo
May 2011

Introduction

States are increasingly exploring and implementing All-Payer Claims Databases (APCDs) as one tool to inform policymaking, research, delivery system design, and other activities. Planning efforts related to the Affordable Care Act (ACA) and the Health IT for Economic and Clinical Health (HITECH) Act demand increasingly sophisticated analytics, particularly given the size and scope of these new programs. As such, clear, comprehensive and easily-accessed data support a number of key goals:

- Data-driven policy and legislative efforts
- Consumer engagement and informed decision making
- Quality improvement
- Health care cost and utilization management
- Improved population health
- Private and public sector contracting decisions

For the purposes of this project, APCDs were defined as follows: a database, usually created by state mandate, although some voluntary databases exist, that typically includes data derived from medical, provider, pharmacy, and dental claims, along with supplemental eligibility and provider files, from private and public payers.[1]

Project Activities

In order to assist the California HealthCare Foundation (CHCF) in determining the feasibility of establishing an APCD in California, Manatt Health Solutions (Manatt), with technical expertise from the All-Payer Claims Database Council (APCD Council), led a series of activities designed to understand stakeholder views and identify areas of consensus on APCD planning in the following domains: governance, use cases and functions, business requirements, financing and cost estimates, and an investigation of related policy and legal issues. Activities specifically included the following:

- **Review of other state approaches to APCD implementation.** Information from 12 other states was compiled and analyzed to determine steps and requirements necessary to establish and maintain an APCD.

- **Stakeholder interviews.** Phone interviews were conducted with stakeholders representing 25 organizations, including health plans, independent practice associations, provider associations, state agencies, the state legislature, consumer organizations, purchasers, researchers and others. The purpose of the interviews

[1] Adapted from the APCD Council.

was to: obtain feedback on potential uses of an APCD in California; assess priorities and interests; and define an APCD business rational and value proposition, governance models options, and financing opportunities.

- **Analysis of options and development of governance models**. These models addressed: composition of a board of directors; entities serving in an advisory capacity; options for public, private and hybrid approaches; procurement, requirements development, and day-to-day administration; mandatory versus voluntary participation; and other factors. This resulted in three governance approaches, ranging from a completely state-sponsored effort to a private effort.

- **Review of policy and regulatory landscape**: Researched relevant federal and state laws and regulations that could shape development and implementation of an APCD in California and limit or justify its operational requirements. This analysis included ERISA, HIPAA, California's Confidentiality of Medical Information Act, and other statute. Other provisions, such as those governing the Office of Statewide Health Planning and Development (OSHPD) and CalPERS data collection, were examined. Manatt's analysis also highlighted:
  - Implications of the requirements for a voluntary versus mandatory submission of data to an APCD, including the impact on privacy protections and rules;
  - Potential regulatory action that could be undertaken to compel APCD participation by data submitters; and
  - Regulations affecting data access and release policies.

- **Identification of key business requirements.** A broad range of business requirements and use cases was assessed to determine those most relevant to California stakeholders. This assessment included current or future requirements associated with existing entities, such as the nascent Health Benefit Exchange, support for a variety of voluntary initiatives including the California Cooperative Healthcare Reporting Initiative (CCHRI) and the Integrated Healthcare Association's (IHA) Pay-for-Performance Initiative, cost, utilization and quality reporting opportunities, etc.

- **Development of cost models and funding opportunity assessment:** Manatt analyzed other state funding models, evaluated the implications for California and developed start-up and ongoing cost estimates. Various financing options were explored (e.g., user fees, data access fees, assessments, Medicaid matching funds, grants and other potential funding sources). Costs included:
  - Initial costs estimates related to data integration;
  - Ongoing maintenance costs, including staffing, technical components, etc.;
  - Development and maintenance of policies for data use, privacy and security, etc.; and
  - Day-to-day administrative costs.

Based on project scope, Manatt provided initial and ongoing cost estimates based on information collected from other states and initiatives and extrapolated to account for California's unique attributes. Manatt did not carry out a comprehensive business modeling exercise; therefore, an evaluation of potential cost savings was not completed.

- **Stakeholder convening.** In an effort to develop consensus on a model and go-forward strategy, a core group of stakeholders was convened to determine if there was sufficient agreement about the need, business rationale, value proposition and utility of an APCD to advance planning and implementation efforts. The goal for the convening was to identify critical issues and key considerations and to understand potential barriers, obstacles, opportunities and uses of an APCD.

Convening Summary and Findings

In April 2011, a group of 18 stakeholders was convened in an effort to develop consensus and define elements to construct a roadmap for a California APCD. Feedback was mixed. There was general consensus of the implicit utility in developing an APCD (i.e., in one sense, that an APCD could be considered a public good), however stakeholders were unable to agree on the value of specific APCD functions (i.e., what it would do, what questions it would answer). The current economic climate in California forced these questions: Who would receive the most value? Who would be *willing* to pay for an APCD? With that pretext, the value proposition and business rationale to underwrite the estimated start-up and ongoing costs could not be agreed to by stakeholders.

There were other areas of general consensus from the stakeholder interviews and convening, including:

- ***Governance Model*:** Of the three governance options, there was general consensus that a state legislated, public-private partnership, with mandatory carrier (and potentially delegated provider) participation was most promising. Under such a model, the State would pursue legislation to identify or create a non-profit public benefit corporation (501(c)3) with both ex-officio and private stakeholder board members. Legislation would require carriers to participate and contribute claims data to the non-profit. The legislation could further establish an Advisory Board to make recommendations as to: board member composition, specific functions to be carried out by the non-profit, identification of a business plan, and recruitment of an executive officer.
- ***Business Requirements***: There was general consensus that the APCD could serve to consolidate existing claims reporting requirements from carriers to the many voluntary efforts (e.g., CCHRI, IHA-P4P, CPPI, others) and establish a single data source. This could help ensure data are timely, actionable, and of high quality. Many carriers participate in these current initiatives and provide separate data feeds for each. Consolidation through an APCD should enable efficiencies to be realized.

- ***Functional Requirements***: Most participants agreed that there is a strong case to be made that the real value in an APCD would ultimately arise when the APCD's administrative data could be linked to other data sources (e.g., clinical data from health information exchanges, public health, etc.). For this reason, it was deemed to be key that patient-identifiers should be captured.
- ***APCD Relationship to the Health Benefit Exchange (HBE)***: Established under the ACA, HBEs are required to incorporate risk-adjustment methodologies by 2014. As such, there was interest in investigating whether an APCD could be used as a source of claims data to risk adjust premiums, and/or to provide a methodology or service to the HBE to provide a risk adjustment score for prospective HBE beneficiaries.
- **Identification of Project Champions.** Lessons learned from other state APCD implementation efforts is that a key element of success is the driving force of a project champion or champions, most frequently representing a state entity. Champion(s) should be perceived as relatively neutral and who can effectively work with a broad range of stakeholders in consensus building. Another element of success has been state policy leadership in planning and implementation.

Suggested Next Steps

Despite a number of areas of consensus, at no stage in Manatt's process did stakeholders articulate a clear and compelling case to advance to an APCD implementation stage. Stakeholder interest was, however, sufficient to recommend further research, additional stakeholder engagement, and the need to identify project champions.

More specifically, Manatt recommends four potential next steps:

Recommendation 1: Engage in conversations with Health Benefit Exchange representatives to identify potential areas for collaboration.

As previously indicated, the ACA requires risk adjustment by 2014; this requirement applies to health plans in the small group and individual markets both inside and outside California's HBE. Risk adjustment will allow plans with high-risk enrollees to be compensated by plans with low-risk enrollees, regardless of whether the plan is offered inside or outside of the Exchange. This minimizes adverse selection and compensates plans with higher risk patient profiles. Risk adjustment scores are based on clinical conditions, typically captured through claims data. They may also be captured through clinical and self-reported data. To establish a fair process across insurers, an APCD could be used to establish a state risk adjustment program. Given its involvement by plans both inside and outside of the Exchange, other regulators (e.g., Department of Managed Health Care, Department of Insurance) should be involved in the analysis of the potential role for an ACPD. Further investigation of this option should be considered.

***Recommendation 2**:* Identify project champions.

In most other states with APCDs, a key component of success has been identification of project champions representing a number of different sectors. Engagement of champions could position APCD creation as meeting market and policy needs in California, rather than simply a foundation-driven initiative. In other states, these champions have typically been legislative or administration leaders. Should an APCD be developed in California, it may be necessary to identify a champion that is either a member of the legislature or a senior administration official and link the APCD to a core policy objective.

Successful implementations in other states have tended to be *consensus driven*. In such a process, a party, generally considered neutral, drives the discussion with stakeholders who collectively have varying opinions and viewpoints as to what an APCD core functions should be. The neutral third party helps lead the discussion towards a successful outcome – a definition of critical policy objectives and a set of functions that will fulfill those policy objectives.

***Recommendation 3**:* Continue to refine possible models

A smaller roundtable should be planned, targeting fewer than ten stakeholders, to discuss business requirements and the APCD value proposition in California. The discussion should specifically consider Recommendations one and two and key takeaways from the convening as discussed above to narrow the focus of the discussion. This narrow focus could facilitate a more concrete determination about whether or not to proceed with APCD planning, who the right leaders are, and what policy objectives an APCD could support. Stakeholders would likely represent a number of the entities involved in planning and could assist in identifying project champions.

Recommendation 4: Improve the availability of existing data.

Identify opportunities to make data related to health care costs and utilization more easily accessible. These data may include those associated the Medi-Cal, public health (e.g., facility and incident reports), CalPERS, and others.