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Introduction

Increasing attention to enhancing the quality of care and patient experience, slowing the rate of health care spending, and improving health outcomes is contributing to a greater demand for meaningful and actionable information to support state health care system evaluation and improvement strategies. Multi-payer claims databases are one such source of information that, when used effectively, can provide insight into how states' health care systems are functioning and facilitate data-driven decision-making.¹ In 2014, the Robert Wood Johnson Foundation's State Health and Value Strategies program supported a series of issue briefs on all-payer claims databases (APCDs) for states seeking to implement and optimize claims databases.² As of January 2019, 21 states have passed legislation to mandate an APCD. Of those 21, 16 are operational.³

Community organizations, including regional quality improvement collaboratives and employer-led coalitions, have also created multi-payer claims databases as a means to drive improved health care value and health status.

This brief looks at the progress several states and community organizations have made in using their multi-payer claims databases for various strategic purposes, and offers considerations for states that are seeking to optimize their own claims databases to achieve health care system performance improvement goals.⁴ It identifies three broad data use categories and provides a high-level description of the approaches taken by select states and one community organization, with attention to practices that may not be as widely used across states, or in areas that states and community organizations are just beginning to pursue.

Data Use Strategies

Multi-payer claims databases hold the potential for states to identify major drivers of health care costs and utilization patterns, and generally gain a better understanding of how their health care system performs. Many states have been leveraging their claims databases for sophisticated analyses of quality and costs of health care, including provider, payer, and geographic variation in quality and utilization. Examining performance variability and benchmarking performance of providers against regional and statewide averages holds the potential to:

- > Reveal areas of opportunity for which states, insurers and/or providers may wish to focus attention and resources.
- > Identify regional/geographic opportunities for improvement or interventions targeting community-specific needs.
- > Guide discussions of appropriateness of care, sharing of best practices from higher performers, and inform strategies to reduce variation deemed to be inappropriate and/or contributing to wasteful spending.
- > Assess the extent to which price, volume, service mix, and location of care are contributing to health care spending growth.

States are applying their findings to support ongoing regulatory activity and inform policy decisions, promote transparency, and drive delivery system activity. The following table includes those data use categories and examples from states and one community organization of how they are using their databases for specific purposes. These are just a few of the ways in which the entities are leveraging their databases.

Data Use Categories and Examples ⁵

(1) Support ongoing regulatory activity and analysis of potential policy initiatives

- > **New Hampshire:** The New Hampshire Insurance Department is authorized by statute to collect data from insurance companies and third-party administrators to make “available as a resource for insurers, employers, providers, purchasers of health care, and state agencies to continuously review health care utilization, expenditures, and performance in New Hampshire and to enhance the ability of New Hampshire consumers and employers to make informed and cost-effective health care choices.” The state has produced a variety of ad hoc reports, often at the request of legislators, that are relevant to areas of insurance regulation and policy and has used the APCD to analyze and inform policy decisions related to expanding the age of dependent coverage, reimbursement rates for mental health services, patient cost-sharing, and balance billing. Currently, the state is using its APCD data to develop (1) an approach to evaluate network adequacy, and (2) techniques to support identification of health care billing fraud.
- > **Oregon:** Oregon’s All Payer All Claims Database (APAC) is used by the Oregon Health Authority (OHA) for many purposes, including analyzing its primary care medical home model and Patient Centered Primary Care Home (PCPCH) program. OHA analyzed four years of APAC data to assess changes in patterns of utilization and spending across clinics participating in the PCPCH program. OHA found that for every dollar increase in primary care spending from the PCPCH program, there was an average of \$13 in savings in other services (e.g., specialty care, emergency department (ED) use, and inpatient care). The evaluation, in part, led to the passing of a law in 2015 requiring OHA to collect and report data on the proportion of medical expenses allocated to primary care decisions, and another in 2017 establishing a 12 percent minimum spend on primary care by 2023.⁶ In August 2018, the state produced a use case document, listing the ways in which APAC data have been used by different internal and external parties.⁷

(2) Promote transparency for consumers and policymakers with cost and quality reporting and tools

- > **Massachusetts:** The state’s Health Policy Commission (HPC) uses the state’s APCD to support its mission to investigate, analyze, and report trends and insight into the health care system. The HPC has analyzed spending patterns by provider group, which includes total spend, spending by category of service and spending on low-value care, and uses claims data to analyze out-of-network spending and variation in hospital prices for low-risk births. Another state entity, the Center for Health Information Analysis (CHIA), uses the APCD to routinely report on a range of health care metrics, including total health care spending and other spending indicators, readmission rates, and insurance coverage. In August 2018, CHIA produced a report on prescription drug use and spending utilizing a subset of pharmacy claims data in the state’s multi-claims payer database. Finally, CHIA and the HPC use the claims database to measure health care system performance against the state’s annual health care spending target.⁸
- > **Washington Health Alliance (Alliance):** The Alliance is a regional health improvement collaborative that brings together stakeholders to improve health care system performance. The Alliance produces several reports focusing on health care quality, regional variation in utilization of specific services, and wasteful spending. In February 2018, the Alliance published a report analyzing low-value health care services across the state, measuring 47 common tests, procedures, and treatments that Choosing Wisely and the U.S. Preventive Services Task Force determined to be overused. It will soon begin reporting on spending trends, cost of potentially avoidable care, and price variation of common procedures and tests.

(3) Support specific regional or provider-level delivery system improvement activity

- › **Vermont:** The Vermont Blueprint for Health publishes bi-annual regional service area profiles of health status, health care utilization, and quality measures. It uses data primarily from Vermont's APCD, which includes all covered commercial, Medicaid and Medicare members attributed to the primary care practices participating in the Blueprint for Health practices, and the state-initiated primary care transformation program. In addition to the claims data, the Blueprint profiles use the clinical data that flow from practice and hospital electronic medical records into the Blueprint Clinical Registry. The profiles provide information about variation in cost, utilization and quality, and compare regions to statewide averages on many metrics. Regional collaboratives use community health profile data to identify performance improvement opportunities and develop initiatives, while practices do the same at the practice level. Blueprint staff facilitates the use of its reports for these purposes.

Lessons Learned from States and Community Organizations Using Multi-Payer Claims Databases

With more experience using claims databases, and more sophisticated analyses, states and community organizations have many lessons to offer to other states and coalitions seeking to optimize their own databases, including:

- › **Obtain active and continuous engagement of stakeholders:** Continuous provider, payer, and consumer engagement is critical to building buy-in and trust, and states play an important role bringing stakeholders together. A process that engages these stakeholders in development of a data use strategy allows for collective decision-making about how to best enhance and leverage claims databases. Payers, providers, and consumers offer critical perspectives for turning data into meaningful and actionable information, which may lead to delivery system changes that may not have otherwise happened. States can engage providers, payers, and consumers in the development of public-facing reports, dashboards, or other tools that can be used to assess health care system performance and identify priority opportunities for improvement. Involving stakeholders throughout the process creates more ownership of the outputs and increases an understanding of the data findings. It will also make publicly-reported information more meaningful to policymakers, consumers, providers, payers, or other stakeholders.
- › **Engage in responsible testing of data prior to release:** Data that has been adequately and thoroughly tested, validated, reviewed and analyzed should provide a measure of confidence of readiness for release. State and national experts suggest that testing include a dry run with providers and payers to provide an opportunity to address inconsistencies or errors prior to public release. Following public release of data, processes should be modified to address and correct issues.
- › **Circulate data and findings broadly:** Following adequate opportunity for provider and payer review, data should be circulated widely to focus attention on findings, promote discussions that are data-informed, and enable researchers, community-based organizations and others to analyze the data, learn from the analysis, and act. Increasing the availability and accessibility of data provides a means for stakeholders, including health care consumers, to engage in the policy decision making process. Once information is released, discussions of opportunities and sharing of best practices can begin in earnest.
- › **Consider how state analysis should complement that occurring at provider and payer levels:** Many providers and payers are already performing their own analyses regarding the populations they serve using more real-time data than claims databases can provide. States should consider how their broad data use strategy could focus resources to support providers with less advanced data capabilities, and not duplicate efforts of providers and payers already performing their own analyses. In addition, states may wish to think about what activities and uses of claims databases could augment provider and payer analyses. For example, states could use their claims databases to provide a deeper dive into specific areas or identify patterns, or trends, that could inform targeted interventions and policies.

Conclusion

Multi-payer claims databases hold the potential for states to gain insight into how their health care systems are operating. States should ensure that the way in which they are leveraging their data result in meaningful and actionable information that the state, payers, providers, researchers, advocates, and others can use to improve care for patients and overall performance of the system. States can use their databases to inform policy decisions, promote transparency through cost and quality reporting, including identifying where there is variation in cost and quality, and to drive delivery system changes. A well-defined strategy developed with input from stakeholders can support state efforts to enhance the functionality and impact of claims databases and support system transformation goals.

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ABOUT STATE HEALTH AND VALUE STRATEGIES — PRINCETON UNIVERSITY WOODROW WILSON SCHOOL OF PUBLIC AND INTERNATIONAL AFFAIRS

State Health and Value Strategies (SHVS) assists states in their efforts to transform health and health care by providing targeted technical assistance to state officials and agencies. The program is a grantee of the Robert Wood Johnson Foundation, led by staff at Princeton University's Woodrow Wilson School of Public and International Affairs.

The program connects states with experts and peers to undertake health care transformation initiatives. By engaging state officials, the program provides lessons learned, highlights successful strategies and brings together states with experts in the field. Learn more at www.shvs.org.

ABOUT BAILIT HEALTH

This brief was prepared by Erin Taylor and Michael Bailit. Bailit Health is a health care consulting firm dedicated to ensuring insurer and provider performance accountability on behalf of public agencies and private purchasers. For more information on Bailit Health, see www.bailit-health.com.

Endnotes

1. The 2016 Supreme Court decision in the *Gobeille vs. Liberty Mutual Insurance Company* case restricts states' authority to require self-funded insurers and their contracted third-party administrators to submit claims information to APCDs. For this reason, and for the purposes of this brief, the authors will use the term "multi-payer claims databases" to describe states' claims databases in the time since the court decision. The authors recognize that the term APCD is generally applied to state databases even if data is not collected from all payers.
2. See *Applicability of All-Payer Claims Databases for Rate Review and Other Regulatory Functions, Realizing the Potential of All-Payer Claims Databases: Creating the Reporting Plan and The Basics of All-Payer Claims Databases: A Primer for States*.
3. APCD Council. Interactive State Report Map. 2019, January 11. Retrieved from: <https://www.apcdouncil.org/state/map>.
4. This includes regional quality improvement organizations and employer-led multi-stakeholder coalitions, among others.
5. The Rhode Island Healthcare Cost Trends Project is a collaboration between the Office of Governor Gina M. Raimondo, the Office of the Health Insurance Commissioner, and the Executive Office of Health and Human Services, who are working with Brown University's School of Public Health on a data-driven health care cost trend analysis. The project is funded by a grant from the Peterson Center on Healthcare to Brown University. On November 14, 2018, the project hosted a conference to explore how states are leveraging multi-payer claims databases, with speakers including: David Auerbach, Director of Research and Cost Trends, Massachusetts Health Policy Commission; Tyler Brannen, Director of Health Economics, New Hampshire Insurance Department; Nancy Giunto, Executive Director, Washington Health Alliance; Mary Kate Mohlman, Health Services Researcher, Vermont Blueprint for Health; and Stacey Schubert, Research and Data Manager, Oregon Health Authority. Information and speaker presentations can be accessed here: <http://www.ohic.ri.gov/ohic-reformandpolicy-costtrends.php>.
6. The minimum spend on primary care applies to state employee health care purchasers, commercial carriers including Medicare Advantage and Coordinated Care Organizations (Oregon's Medicaid managed care plans.)
7. In Oregon, HealthInsight Oregon, a private, nonprofit organization also collects and analyzes the commercial claims of approximately 80 percent of Oregonians. HealthInsight Oregon has facilitated a multi-stakeholder committee that makes decisions about how data will be reported to payers, providers and the public with a focus on cost and quality information. The reports highlight areas of opportunity to improve performance for health plans and providers. HealthInsight also supports providers either through training or direct assistance in interpreting the reports and understanding the scope of the reports and action that can be taken to improve performance.
8. Massachusetts Chapter 224 of the Acts of 2012, "An Act Improving the Quality of Health Care and Reducing Costs Through Increased Transparency, Efficiency and Innovation" established a health care cost growth benchmark, a statewide target for the rate of growth of total health care expenditures. For the first five years of implementation (2013 to 2017), the law required the cost growth benchmark to be equal to the potential gross state product (PGSP). Beginning in 2018, the law requires the benchmark to be PGSP minus 0.5 percent; however, the state's Health Policy Commission Board has the authority to modify the benchmark.