Comments in Response to: Center for Medicare and Medicaid Innovation Request for Information on State Innovation Model Concepts

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The APCD Council commends CMS for providing an opportunity to provide feedback to inform the planning for possible future State Innovation Model (SIM) projects.

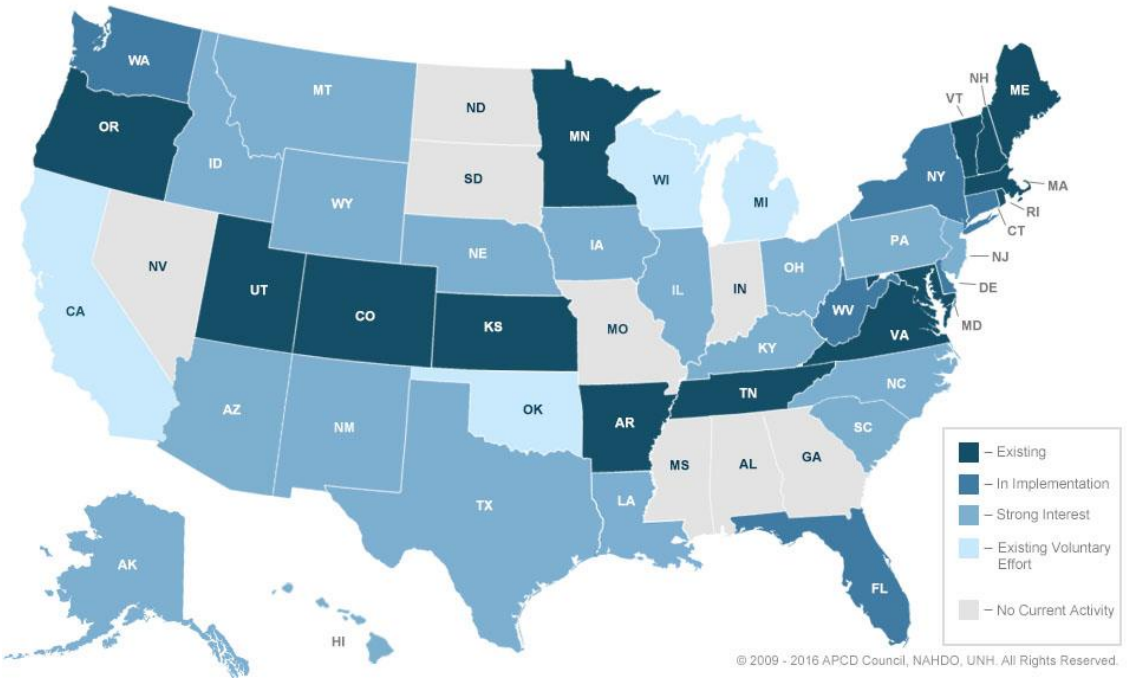
The APCD Council is a learning collaborative of government, private, non-profit, and academic organizations focused on improving the development and deployment of state-based all payer claims databases (APCDs). The APCD Council is convened and coordinated by the Institute for Health Policy and Practice (IHPP) at the University of New Hampshire (UNH) and the National Association of Health Data Organizations (NAHDO).

As noted in the Request for Information (RFI), "CMS has set ambitious goals for health system transformation, and we recognize that much of this transformation will ultimately occur at the state and community level. Our investment in SIM is a recognition of the important role states play as a locus for change to accelerate transformation, and their unique leverage point to implement models consistent with the proposed Quality Payment Program under the Medicare Access and CHIP Reauthorization Act (MACRA) legislation." As states invest resources and energy in the transformation efforts that are part of SIM and other state initiatives, the need for data at the state and local level data will be essential in order to inform and evaluate transformation efforts. It is with this data lens that we developed this response to the RFI.

The APCD Council comments are focused on CMS' interest in understanding the necessary data infrastructure at the state level to support transformation. Specifically, the comments address the questions posed in "SECTION I: MULTI-PAYER STATE-BASED STRATEGIES TO TRANSITION PROVIDERS TO ADVANCED ALTERNATIVE PAYMENT MODELS, question 4: "Based on experiences in other states, CMS believes that data are available through a multitude of pathways (e.g., directly from hospitals, health systems, or third party payers), but CMS is interested in the input from potential participants, including providers, states and other payers, on access to data."

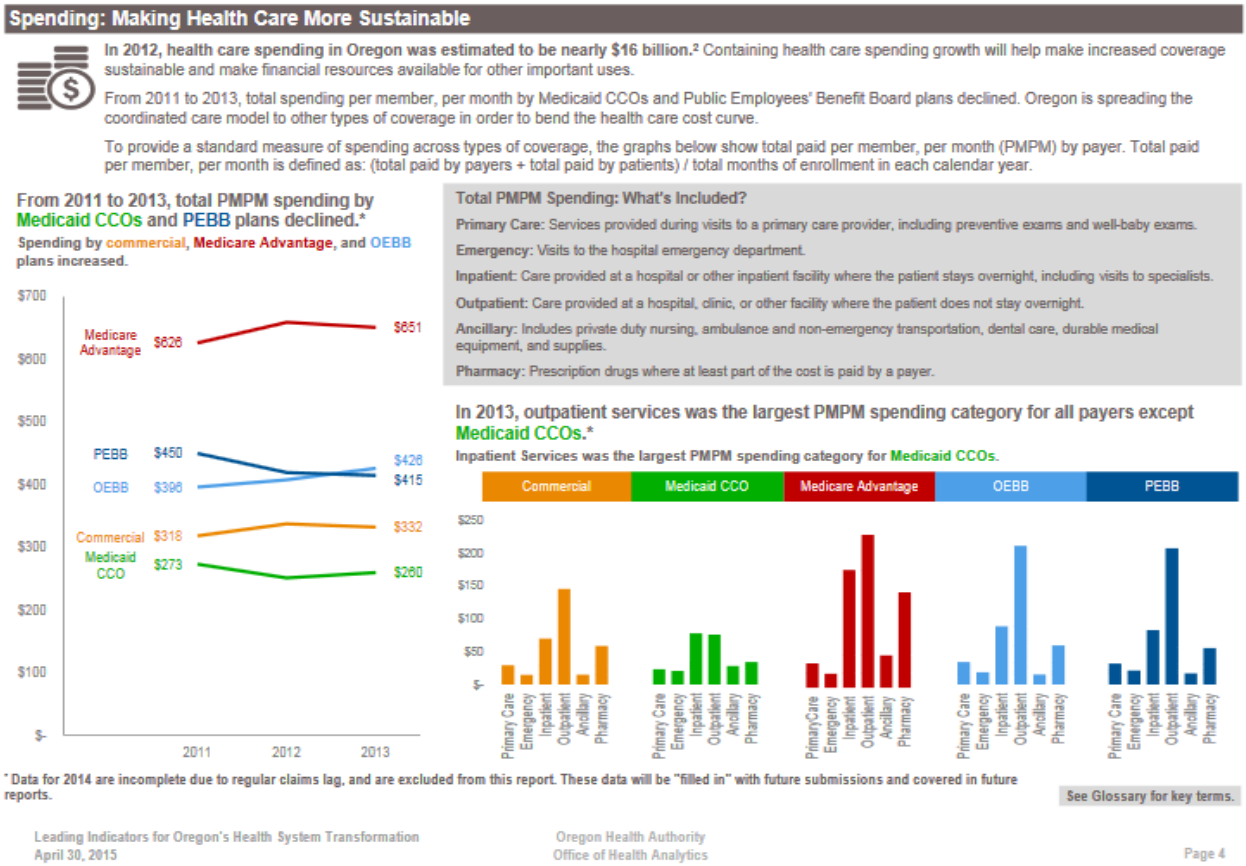
3a. To what extent do states, all-payer claims databases (APCDs), payers, and other key stakeholders have access to reliable and timely data to calculate spending benchmarks and to monitor Medicare and multi-payer total cost of care trends in the state? Do states have integrated Medicare-Medicaid data?

Currently, 19 states currently have or are implementing APCDs (see the map below). Statewide APCDs are: Databases, typically created by a state mandate, that generally include data derived from medical claims, pharmacy claims, eligibility files, provider (physician and facility) files, and dental claims from private and public payers. With this breadth of data collection, states with APCDs with have access to multi-payer claims data that can provide the benchmarks and monitoring of trends for Medicare, Medicaid, and commercial populations.



Examples of how states have been able to use the APCD for benchmarking and monitoring include:

Oregon: The Oregon Health Authority published a report that provides comparisons of Per-Member Per-Month costs, by service category, for commercially insured, public employees, and public payers. This report has been developed as part of the reporting to support Oregon's Health System Transformation effort (http://www.oregon.gov/oha/analytics/APACPageDocs/Leading-Indicators-Report-April-2015.pdf).



Spending: Making Health Care More Sustainable

In 2012, health care spending in Oregon was estimated to be nearly $16 billion.[2] Containing health care spending growth will help make increased coverage sustainable and make financial resources available for other important uses.

From 2011 to 2013, total spending per member, per month by Medicaid CCOs and Public Employees' Benefit Board plans declined. Oregon is spreading the coordinated care model to other types of coverage in order to bend the health care cost curve.

To provide a standard measure of spending across types of coverage, the graphs below show total paid per member, per month (PMPM) by payer. Total paid per member, per month is defined as: (total paid by payers + total paid by patients) / total months of enrollment in each calendar year.

From 2011 to 2013, total PMPM spending by Medicaid CCOs and PEBB plans declined.*

Spending by commercial, Medicare Advantage, and OEBB plans increased.

Total PMPM Spending: What's Included?

Primary Care: Services provided during visits to a primary care provider, including preventive exams and well-baby exams.

Emergency: Visits to the hospital emergency department.

Inpatient: Care provided at a hospital or other inpatient facility where the patient stays overnight, including visits to specialists.

Outpatient: Care provided at a hospital, clinic, or other facility where the patient does not stay overnight.

Ancillary: Includes private duty nursing, ambulance and non-emergency transportation, dental care, durable medical equipment, and supplies.

Pharmacy: Prescription drugs where at least part of the cost is paid by a payer.

In 2013, outpatient services was the largest PMPM spending category for all payers except Medicaid CCOs.*

Inpatient Services was the largest PMPM spending category for Medicaid CCOs.

* Data for 2014 are incomplete due to regular claims lag, and are excluded from this report. These data will be "filled in" with future submissions and covered in future reports.

See Glossary for key terms.

Leading Indicators for Oregon's Health System Transformation
April 30, 2015

Oregon Health Authority
Office of Health Analytics

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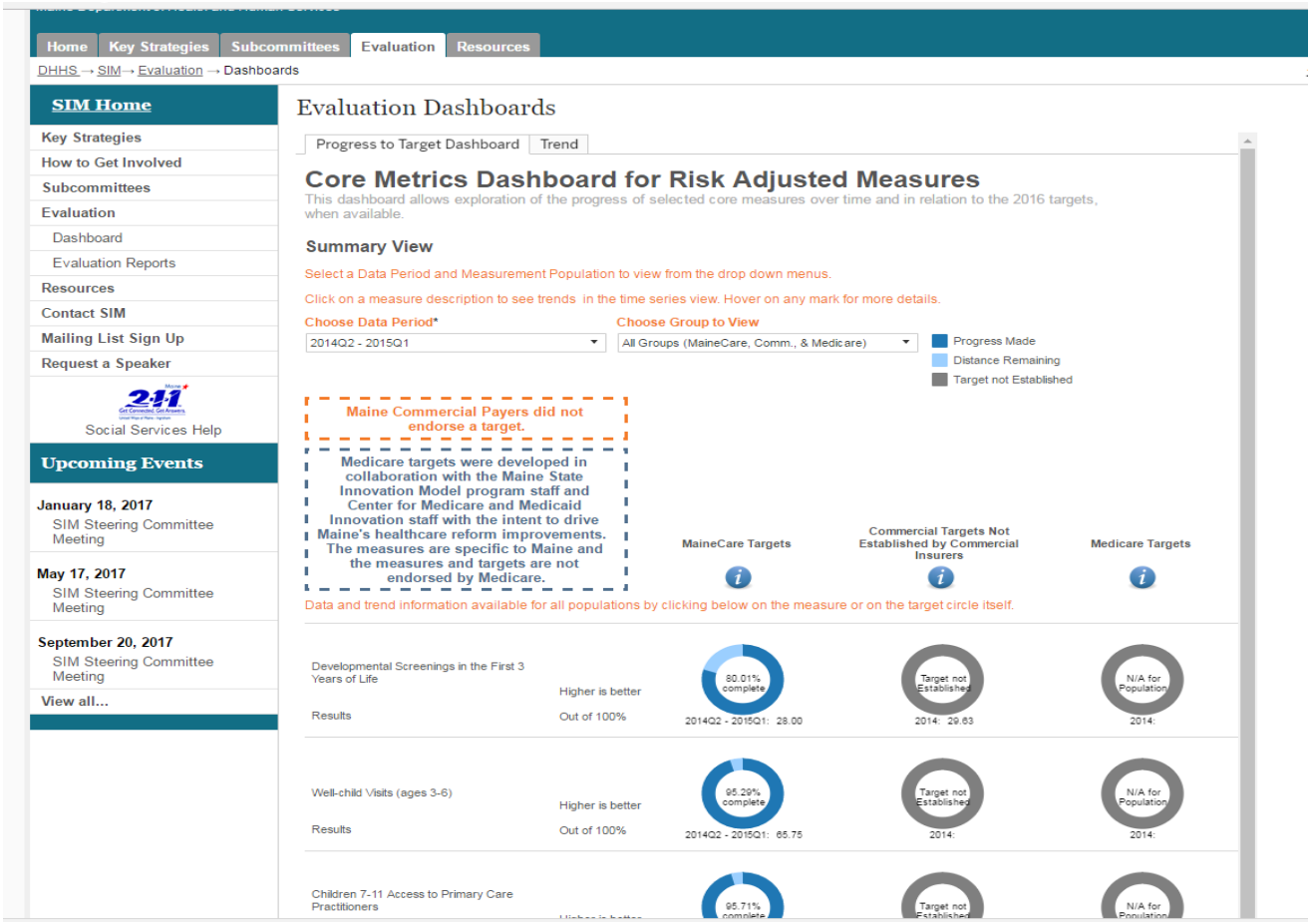
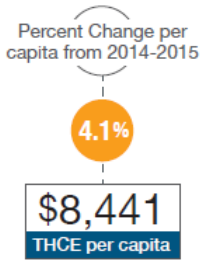
Maine: The State of Maine has used its APCD data to develop dashboards to support its SIM efforts, providing benchmarks across many key metrics (http://www.maine.gov/dhhs/sim/evaluation/dashboard.shtml).



Massachusetts: The MA Center for Healthcare Information and Analysis (CHIA) develops an annual report of health care costs and expenditures by population, types of service, and geography to support its larger system transformation effort statewide (http://www.chiamass.gov/assets/2016-annual-report/2016-Annual-Report-rev-1.pdf).

HEALTH CARE EXPENDITURES PER MASSACHUSETTS RESIDENT WERE $8,441 IN 2015—AN ANNUAL INCREASE OF 4.1%.

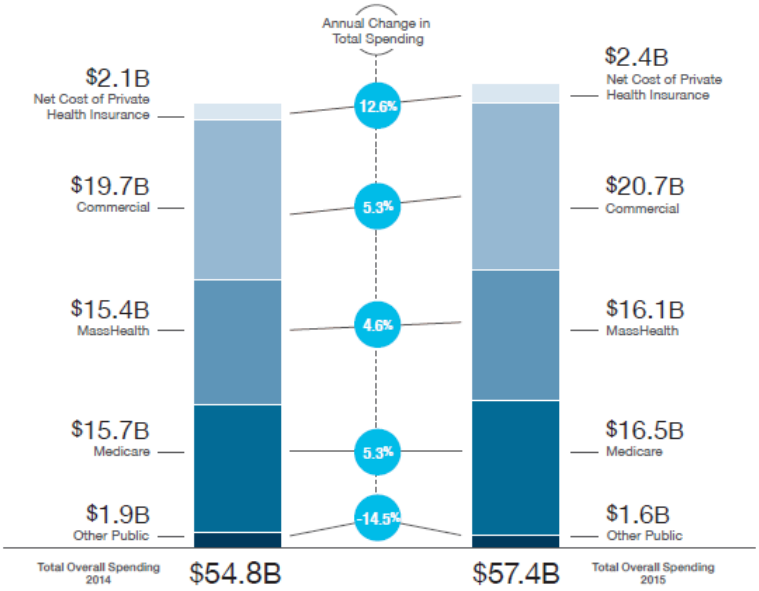


Source: Payer-reported data to CHIA and other public sources. See technical appendix.

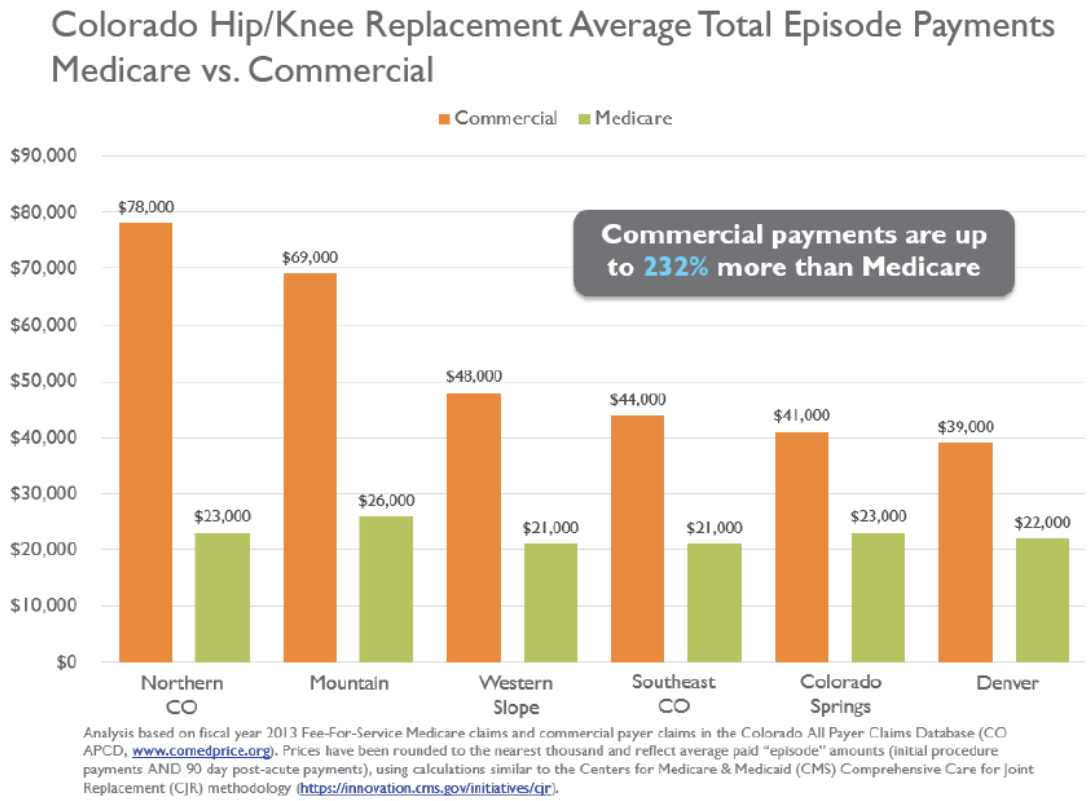
Notes: Percent changes are calculated based on non-rounded expenditure amounts. Please see databook for detailed information.

2 Components of Total Health Care Expenditures, 2014-2015

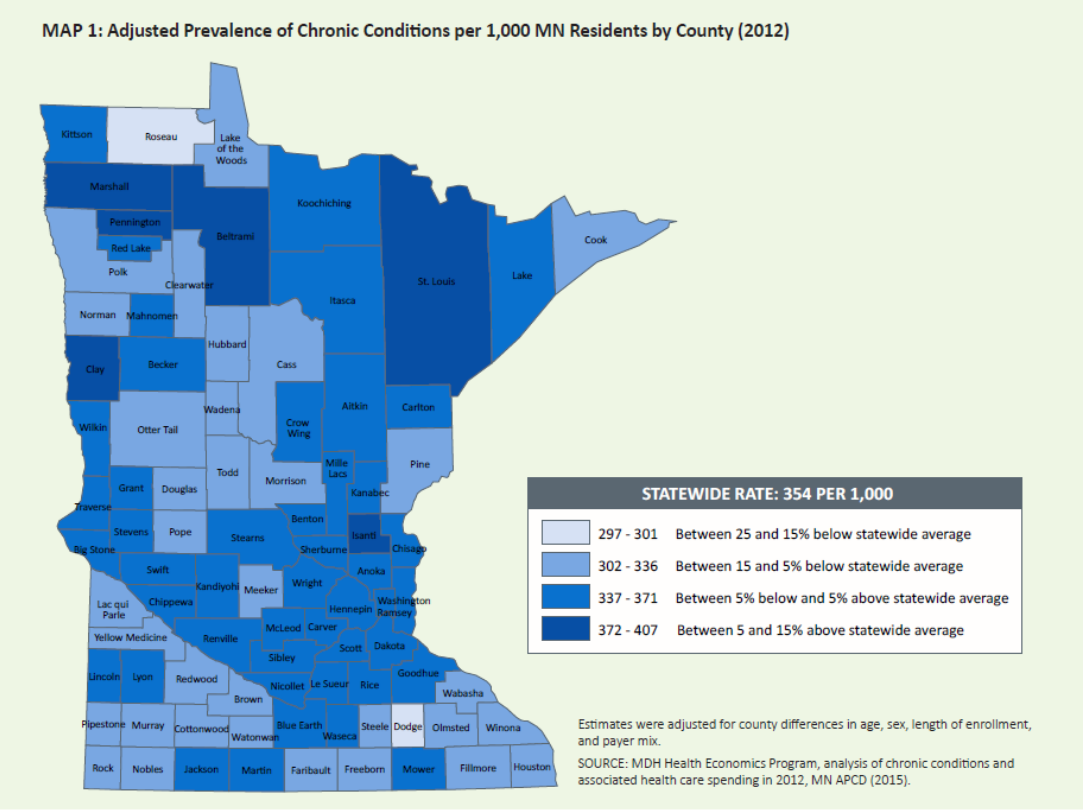
THCE represents the total amount paid by or on behalf of Massachusetts residents for insured health care services. It includes the NCPHI (non-medical spending by commercial health plans), and medical spending for commercially and publicly-insured Massachusetts residents.



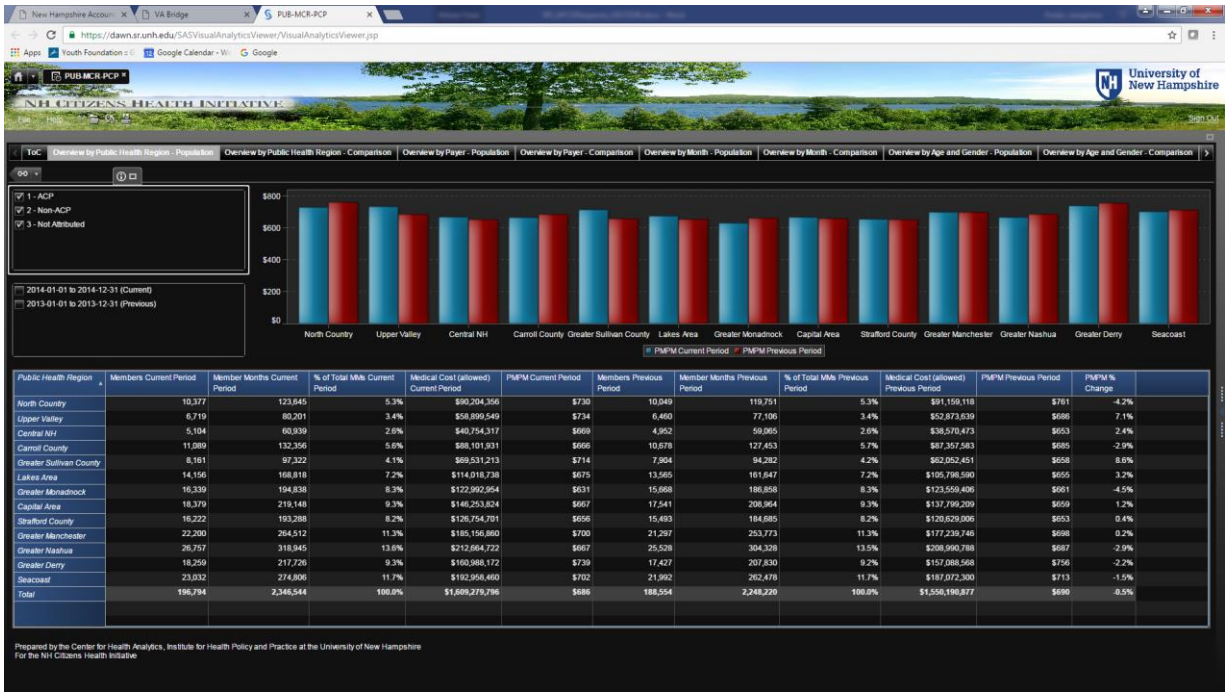
Colorado: Among the analysis and reporting from the Center for Improving Value in Health Care (CIVHC)'s reporting are comparisons of costs for commercial and Medicare for common health care services (https://www.comedprice.org/#/home).



Minnesota: The State of Minnesota recently published a report focused on the prevalence and cost of chronic conditions in the state, providing comparison for populations with different disease profiles and by geographic region (http://www.health.state.mn.us/divs/hpsc/hep/publications/costs/20160127_chronicconditions.pdf).



New Hampshire: A reporting effort in the New Hampshire provides comparison reports for cost and utilization for commercial, Medicaid, and Medicare insured individuals, reported statewide and by public health region (www.nhaccountablecare.org).



Public Health Region	Members Current Period	Member Months Current Period	% of Total MMs Current Period	Medical Cost (allowed) Current Period	PMPM Current Period	Members Previous Period	Member Months Previous Period	% of Total MMs Previous Period	Medical Cost (allowed) Previous Period	PMPM Previous Period	PMPM % Change
North Country	10,377	123,645	5.3%	$90,204,356	$730	10,049	119,751	5.3%	$91,159,118	$761	-4.2%
Upper Valley	6,719	80,201	3.4%	$58,899,549	$734	6,460	77,106	3.4%	$52,873,639	$686	7.1%
Central NH	5,104	60,939	2.6%	$40,754,317	$669	4,952	59,065	2.6%	$38,570,473	$653	2.4%
Carroll County	11,089	132,356	5.6%	$88,101,931	$666	10,678	127,453	5.7%	$87,357,583	$685	-2.9%
Greater Sullivan County	8,161	97,322	4.1%	$69,531,213	$714	7,904	94,282	4.2%	$62,052,451	$658	8.6%
Lakes Area	14,156	168,818	7.2%	$114,018,738	$675	13,585	161,647	7.2%	$105,798,590	$655	3.2%
Greater Monadnock	16,339	194,838	8.3%	$122,992,954	$631	15,668	186,858	8.3%	$123,559,406	$661	-4.5%
Capital Area	18,379	219,148	9.3%	$146,253,824	$667	17,541	208,964	9.3%	$137,799,209	$659	1.2%
Strafford County	18,222	193,288	8.2%	$126,754,701	$656	15,493	184,685	8.2%	$120,629,006	$653	0.4%
Greater Manchester	22,200	264,512	11.3%	$185,156,860	$700	21,297	253,773	11.3%	$177,239,746	$698	0.2%
Greater Nashua	26,757	318,945	13.6%	$212,664,722	$667	25,528	304,328	13.5%	$208,990,788	$687	-2.9%
Greater Derry	18,259	217,726	9.3%	$160,988,172	$739	17,427	207,830	9.2%	$157,088,568	$756	-2.2%
Seacoast	23,032	274,806	11.7%	$192,958,460	$702	21,992	262,478	11.7%	$187,072,300	$713	-1.5%
Total	196,794	2,346,544	100.0%	$1,609,279,796	$686	188,554	2,248,220	100.0%	$1,550,190,877	$690	-0.5%

Prepared by the Center for Health Analytics, Institute for Health Policy and Practice at the University of New Hampshire
For the NH Citizens Health Initiative

Over half of the APCD states are either accessing or applying for Medicare data through CMS, most through the CMS state data request process (https://www.resdac.org/cms-data/request/state-agency). Additionally, about half of the APCD states are working with their Medicaid agencies to include Medicaid data in the data system. The APCD Council website includes a map of states, which details the attributes of each state APCD, including the sources of data collected: http://www.apcdcouncil.org/state/map. In some cases, there is full integration of the data in the data system. In cases where data are not fully integrated into the same data files in the ACPD, these data sources are typically still housed concurrently within the APCD system. This allows the state to analyze data in similar ways.

3b. To what extent do states, APCDs, payers, and other key stakeholders have access to reliable and timely data to calculate quality and population health measures on a Medicare-specific and multi-payer basis, and at the provider level and state level, and to tie payment to health outcome measures (e.g., data sources that include social services, housing, and health care data; appropriate measures)?

As illustrated above, APCD data can be used to calculate a range of population health and quality measures. These data are typically able to be analyzed after sufficient claims lag for adjudication processes, typically about 9 months after the service date. Because state APCDs have historically collected data from the majority of commercially insured lives in a state, there is typically sufficient sample size to allow for sub-state analysis, which is important given the amount of geographic variation in cost and utilization within a state. The APCD Showcase (www.apcdshowcase.org) inventories state reporting and analysis efforts. We encourage a review of that site, because a full description of the myriad ways the data can be used is beyond the scope of this comment.

Worthy of comment, however, is a challenge that states have traditionally had in accurate and consistent provider identification. While the National Provider Identifier is typically well-populated in most state APCDs, there are limitations with provider identification. One major gap is the lack of a standard mechanism to assign providers to group practices. In addition, provider organizations and healthcare facilities often bill under multiple NPIs, and states often attempt to address those issues by developing a master provider file, which is typically a manual effort at the state level.

For states that have done provider-level reporting (e.g., Colorado), one key aspect to the process is the local engagement of the provider community to review the analysis prior to distribution. This can be a key step in identifying data anomalies and addressing issues.

To date, the linking of APCD data to other data sources has been done in limited ways. There are examples of the linking of APCD data with Cancer Registry data, for example, in Maine and New Hampshire. There is also a great interest and some limited examples of linking APCD data to clinical data in Health Information Exchanges (e.g., in Vermont). Tying APCD data to other data sources remains an area of great interest at the state level, and an area of great promise. Of important note, as CMS moves away from using Social Security Number and to assigned identification numbers specific to CMS, the linkage ability is hindered.

As previously mentioned, the breadth of data collection in an APCD allows for sub-state analysis, and reviewing outcomes from APCDs alongside social determinants of health data in similar geographic areas is of great interest to states. This kind of population health approach will require continued building of infrastructure, and a focus on building often underfunded data systems. The movement of states to associating payment to outcomes is in its early stages. There is an opportunity to continue to build not only the data collection and analysis capacity, but also to build the infrastructure for change that will move to different payment approaches that tie payment more directly to outcomes.

3c. To what extent do states have the ability to share Medicaid data with CMS, including any backlogged Medicaid Statistical Information System (MSIS) submissions? Will states be able to transition to the Transformed MSIS (T-MSIS) in time to support this work?

Each state will have unique perspective, and data release policies, for its own MSIS and T-MSIS experience. The APCD Council leaves the input about this issue to each state.

3d. To what extent do states have the capacity, expertise, and staff resources to perform benchmark spending calculations, data aggregation and analysis, and outcomes measurement analysis to implement tying payment to health outcomes measures?

There is varying capacity at the state level to perform analysis and build measurement tools to support transformation efforts. Many states (e.g., Utah, New Hampshire, Maine, Minnesota, and Maryland) rely on a mix of in-house and contractor capacity to meet the analytic needs. Massachusetts is the only state that has the operations and analysis "in-house." In an era of diminishing state budgets, investments in data capacity could result in much more reporting and analysis of health quality, cost, utilization, and outcomes measurement. The state profiles on the APCD Council website provide more detail about the operational approach for each state.

Also worthy of note is that states that have allowed release of data to researchers and others to expand the possibility of the data to be used to support measurement and analysis to support transformation efforts. States have made limited use and public use data files available for release. State data release processes are also listed in the state profiles on the APCD Council website. Examples of research projects that have been submitted to state data release processes can be found in the state summaries of research requests, including in MA (http://www.chiamass.gov/apcd-application-received-and-commenting), Maine (https://mhdo.maine.gov/datarequest.aspx), and New Hampshire (https://nhchis.com/DataAndReport/LimitedUseDataRequests). The data release policies for each state are linked on the profiles on the APCD Council website.

3e. What support can CMS provide to improve states' access to reliable and timely data?

CMS can play an important role in state data improvements. These include:

1. Continued investment in state infrastructure for APCDs. Many states used SIM and other Federal grants to expand data collection, improve data reporting, and/or develop additional infrastructure for data collection. There are many opportunities to do more reporting and analysis with the data, including the linkage examples discussed previously. CMS including those improvements in future grants would allow for important advances at the state level. CMS has been very supportive of states seeking to use Medicaid match funding to support the APCD efforts that are beneficial to Medicaid. Continued support of the use of Medicaid match funding is important.

2. Continued support for state data access. CMS was extremely responsive to state needs for Medicare data, which resulted in the development of the state agency request process. Continuing to identify ways to streamline those requests could be beneficial.

3. Support of state needs for substance use data. States have experienced challenges in acquiring data related to substance use treatment, due to concerns about 42 CFR Part 2. The APCD Council submitted comments to the Substance Abuse and Mental Health Services Administration (SAMHSA) proposed rule modification (https://www.apcdcouncil.org/news/2016/04/apcd-council-submits-comments-sahmsa-regarding-proposed-changes-42-cfr-part-2.) CMS can work with SAMHSA to solve for this issues around this rule, which is vitally important to getting better data to understand substance use issues.

4. Work with the Department of Labor to find a solution for self-funded data. In March 2016, the Supreme Court ruled in *Gobeille v. Liberty Mutual* that Vermont's mandate that requires submission of data could not be enforced for self-insured employers covered by ERISA. The APCD Council and the National Academy of State Health Policy have submitted comments to a rule from the Department of Labor that outlines a solution that addresses the Supreme Court decision that would allow data to continue to be submitted to state APCDs (http://nashp.org/next-steps-for-apcds-us-department-of-labor-dol-rulemaking/). CMS could work with DOL and states in moving that solution forward.

5. Address confusion around submission of Medicare Advantage data to APCDs. In some states, insurers offering Medicare Advantage plans have expressed concerns about submitting those data to state APCDs. While CMS has provided guidance to states indicating that there are no CMS restrictions related to those data, continued clarification on the issue would be helpful.

6. Work with the Office of Personnel Management (OPM) regarding the submission of Federal Employer Health Benefit (FEHB) data. In some states, carriers providing coverage for FEBH plans have expressed confusion about their ability to submit those data to state APCDs. OPM has expressed interest in understanding how it could develop documentation of data procedures at the state level that would allow OPM to provide approval for submission of FEHB plan data to state APCDs. CMS could work with OPM to understand and adopt its state agency approval process.

7. Support state and industry efforts to standardize data collection for APCDs. States and commercial payers have worked extensively to identifying a common approach to data collection in state APCDs. CMS can engage in and support the implementation of those state efforts.

3f. How can CMS support improve access to and linkage with health outcomes measures data?

As previously mentioned, investments in state data infrastructure will be important. In addition, CMS has done terrific work in analyzing and reporting CMS data publically. As CMS develops its methods for that analysis, sharing the methods (as granular as the code to perform analysis) such that they can be replicated at the state level for commercial and Medicaid data could be an interesting next area of work. Finding those CMS-state partnerships could be mutually beneficial. In addition, CMS could promote linkage of data by demonstrating successful linkage of Medicare data, and share that science.

3g. To what extent do states have access to data to perform compliance and program integrity checks to ensure valid outcomes?

Data quality and integrity checks are inherent in the state APCD operational processes. As mentioned previously, most states rely on contractors to support data collection and processing functions. Data quality checks at the file and field level at the time of submission and for analytic uses are in place in APCD operations. More about these levels of quality checking is described in the APCD Development Manual at: https://www.apcdcouncil.org/manual.

3h. What IT infrastructure is available to states to use data to support transformation efforts? (e.g., infrastructure to support the data extraction, transport, transformation, aggregation, analysis, and dissemination of consumer and provider administrative, claims and clinical data)? What infrastructure is necessary to ensure data quality?

APCDs have been in operation in over a dozen states; collecting, managing, analyzing, and releasing APCD data for over 15 years. States and their contractors have developed significant experience in the data collection and analysis systems in that time, including data extract, transform, and load (ETL) functions; aggregation, analysis, and dissemination functions. Infrastructure at the state level includes deep data storage, data release, and analysis expertise, as well as physical infrastructure of servers, security, and computing.

As APCDs have evolved, however, so too have the data collection efforts related to clinical data, individual device data, and other population data. States are in a prime position to make use of these new and existing data sets, but will need investments to support building new capacities in data collection and dissemination to fully realize the potential use of these data to support transformation efforts. This includes technologies that allow for robust reporting while maintaining security, mechanisms to allow for direct and probabilistic linkage, and systems for reporting to a wide range of audiences.

Conclusion

In summary, states have proven to be innovators in the development of APCD data systems and in the effective use of the data from them. There is no shortage of opportunity to continue to build on those efforts. We encourage CMS to continue to work with states to realize this potential, and would be happy to provide additional information.