Testimony
Before the National Committee on Vital and Health Statistics (NCVHS)

on Claims-based Databases for Policy Development and Evaluation

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Good afternoon Mr. Chairman and members of the Subcommittee,

Thank you for the opportunity to provide testimony on behalf of Anthem Inc. regarding our perspective on and experience with Claims-based Databases for Policy Development and Evaluation.

My name is Sheryl Turney and I am the Senior Director, All Payer Claims Database (APCD) Analytics at HealthCore, Inc. (a subsidiary company of Anthem, Inc.) I have been working in the health care industry for over 28 years and for the past 6 years I have provided enterprise leadership to Anthem on the subject of All Payer Claims databases. I am a current member of the Project Management Institute, the CT State Innovation Model Health Information Technology work group, the Virginia Health Information APCD Advisory council and many other healthcare related industry organizations.

Overview of Anthem's APCD efforts

Anthem, as a health care organization at the forefront of innovation, embraces the important role data sharing efforts can play in improving transparency and beneficiary health. At Anthem we recognize genomics, clinical data, patient-generated data and other constantly evolving data sources, technologies, and data analytics platforms have transformed many aspects of our health care delivery system. Anthem submits APCD Data in 12 states, including 3 states in which such submissions are voluntary. Anthem has worked very closely with all state entities in support of APCD implementations and has committed ongoing support to account for annual changes.

We hope that sharing our experience and recommendations with NCVHS will help improve efficiencies and effectiveness of healthcare claim databases. Anthem believes NCVHS can play an important role in advancing transparency by promoting the adoption of a common framework/approach for data collection and use and we thank the Committee for this important opportunity to testify on this topic.

Following are our responses to several of the specific questions posed by NCVHS.

POLICY CONSIDERATIONS FOR DATA SUPPLIERS AND USERS

Examples of benefits and value of claims-based databases, including APCDs, in improving health, quality, access, lowering costs

Anthem's experience is that many APCDs where Anthem submits data were initiated with fairly general goals. The goals that have been communicated and socialized are to use the APCD data to achieve the triple aim of reducing the cost of health care, increasing the quality of health care delivered, and increasing the accessibility to health care services within a specific state or region. However, in our experience the specific approaches, metrics, and data analysis for measuring progress against these objectives are not well defined.

Each state where Anthem reports APCD data makes modifications to the data submission requirements at least annually, and many APCD data collection entities attempt to update their data more frequently—at times with significant push-back from the payer community. The frequency of the changes alone demonstrates a lack of clarity or specificity with respect to the data being requested and how those data will be used. For example, data on race, ethnicity, social security numbers, and temporary residence locations (particularly for students) are often required elements that are not universally populated in claims data.

Some states have used APCD claims data to develop websites which seek to provide cost data for common procedures. These websites often allow residents to compare procedure costs by geographic area or healthcare entity (E.g., across hospitals). Many states also make data available to third parties for research. Data requests go through a process to determine if the data requester meets requirements established by the APCD entity for data stewardship and data use.. The data elements available and the data governance process for these data requests differ from state to state. Some states publish all requests for data as well as a summary of the data use, the outcome of the request, and the contact information for the data requestor; others do not. Many of the APCD claims based databases charge a fee for access to the APCD claims data to help defray the cost of maintaining the databases.

Building a meaningful APCD claims databases is a complex, multi-year effort. Even after APCD entities have committed significant time and resources to such efforts, it is not yet clear if these APCDs have actually achieved their stated goals and objectives. Anthem's recommendation would be to encourage the NCVHS to recommend a common technical architecture similar to the model used by CMS to facilitate the development of a multi-state, federal claims database architecture that would serve multiple reporting and analytical purposes. This common framework should ensure that the minimum necessary data be required for meeting the APCD claims database objectives while ensuring the protection and privacy of patients protected health information by organizations that are HIPAA certified entities.

Anthem has spent significant time, resources, and budget satisfying the data reporting requests of APCD entities. The commitment varies depending on the entity as state APCDs vary in their rules and practices related to collecting and making data available to the data suppliers. Some states, like Virginia- where APCD participation is voluntary – have made the APCD data available to all data submitters through a tool provided by their vendors. Data submitters pay a fee to participate in the Virginia Health Information APCD and receive the public APCD data as a benefit. (VHI masks the Protected Health Information (PHI) data as well as other defined proprietary data elements.) Other states, like Colorado, charge data submitters to receive data from the

APCD and the data request must align with specific "acceptable uses." In our experience, the costs of supplying data to an APCD typically outweigh any benefits derived from receipt of APCD outputs.

Most significant issues in implementing Claims-based Databases and APCDs, including limited populations included; differences between fee-for-service and capitated; lack of identifiers; limitations of claims-based data; differences across states

There have been many challenges with APCD implementation efforts to date. These include a lack of common technical infrastructure and standards across APCDs. Other significant issues include:

- Each APCD's physical database has unique technical and other specifications, requiring data submitters to reformat claims data according to the parameters of each entity's system. This reformatting is resource-intensive and costly for data submitters.
- There is a lack of standardization in terms of the form, content, and submission process for data completeness and quality among states (entities) requiring claims data submissions.
- There is a lack of consistency among APCD state entities with regard to what entities are required to submit claims data. The inclusion/exclusion rules have been impacted by ***Gobeille v. Liberty Mutual Insurance Company***[1] in which the U.S. Supreme Court held that ERISA preempted a Vermont state law that required ERISA employer groups (self-insured) to be data submitters to the Vermont APCD. However, differences in the entities from which data are collected may negatively impact the usefulness and transparency that APCD databases can provide.
- There is a lack of standardization of the data quality and thresholds for data completeness among states APCDs.
- The timeframes applied to the implementation of the APCDs and subsequent changes to submission guides are compressed; the lack of standardization makes it very difficult for data submitters to comply with data submission requirements.
- Many Health Information Exchanges (HIEs) are also now requesting the submission of claims data to be combined with clinical data for reporting, analysis and resale to third parties. These HIE data repositories each have unique requirements.
- The lack of standards or a common infrastructure has resulted in very large databases that do not communicate with one another, require substantial resources and cost to maintain. While there may be pockets of value identified by the various states/entities that run these APCDs, their value has not been quantified or measured against their original stated objectives. The new Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) provider payment rules define the need for CMS to collect significant amounts of commercial claims from data submitters in order to support and inform the quality and cost initiatives under the new rules. At this time, no requirements or standards have been defined for the process or rules by which these data will be collected.

How are Claims-based Databases and APCDs supported; business and sustainability model

For many of the state APCDs there is a process by which data extracts are submitted and go through a pre-process. Once this pre-process is completed (usually within a few days) the data go through a level of threshold checks and data quality checks. The APCD data may also go through an additional level of stratification or verification that results in questions from the state APCD entities to the payers - sometimes weeks, months, or years after the data were originally submitted.

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[1] *Gobeille v. Liberty Mutual Insurance Company. No. 14 Civ. 181 (U.S. Mar. 1, 2016). Available at* http://www.supremecourt.gov/opinions/15pdf/14-181_5426.pdf.

Sustainability of these APCD claims databases is a major concern for both the APCD entities and payers. The current architecture of these databases is typically a large physical database which is complex and costly to administer and maintain. From a data submitter perspective, Anthem follows a formal project development methodology for the implementation and maintenance of data extracts for each state APCD. In addition, Anthem has a team of people across the enterprise that are assigned to support the new and existing APCD data reporting requirements. In order to adequately respond to questions from the state APCDs related to the data, Anthem has effectively been required to build a mirror image of each state's APCD. Over the past 6 years Anthem has spent over $40M to support the APCD submission requirements and the cost continues to grow. We suspect that state APCD entities have spent similarly large sums on APCD creation and maintenance, though no such data are available to the public.

Regarding sustainability, there is some public debate over the practice of the state APCDs selling data to third parties. Concerns for adequate protection of PHI and proprietary APCD data have been raised, particularly concerning data requested/purchased by third parties and related to whether the third party meets HIPAA requirements for data stewardship.

Technical challenges to Claims-based Databases and APCD reporting that inhibit their value

There are many technical challenges to Claims-based Databases and APCD reporting. Claims and Eligibility Data must be modified to meet the processing requirements for each Claims-based/APCD reporting entity. These processing requirements vary by state or Claims-based data reporting entity. There is a lack of standards for APCD data use and claims-based database governance of data requests and data dissemination. Data use challenges include:

- Many APCD entities do not consult with data submitters when evaluating APCD data use.
- Many APCD entities lack transparency with respect to their data subscribers and data uses, despite the fact that these databases are intended to promote transparency.
- Some APCD entities have developed reports, analysis and measures with proprietary methodologies and algorithms, which results in a lack of transparency in the APCD analysis. This lack of transparency with the reporting methods of APCD data reports impacts the ability of researchers, payers, population health, providers and others to willingly collaborate. Collaboration is a very important component to successfully engaging a cross-functional healthcare team to use the data to accomplish the quality, cost and access objectives of the state APCDs.

There is a lack of transparency with APCD data uses. The challenges resulting from variances in allowed APCD or claims-based data uses include:

- Each state is using and funding complex programs, algorithms and logic to ensure patient and subscriber verifiability leading to greater expenses to achieve sustainability.
- Some states are attempting to use the health care claims data to provide reports back to employer groups which may result in anti-competitive negotiating behavior between employers and payers or providers. There is a need for unilateral defined parameters around allowed uses of APCD data that will promote public health without introducing an unequal threat of anti-competitive behavior.

The role of Claims-based Databases including APCDs in a reformed health care system: ACOs, PCMHs, MIPS, and Alternative Payment Models

As the landscape for creative payment models grows, the need for a longitudinal patient record that includes claims data as well as clinical data grows. Most current APCDs currently DO NOT support the variable payment models which increasingly seek to pay providers based on outcomes, quality and episodes of care rather than on claims or discrete encounters. As these new payment models are defined, data requirements for reporting against quality, cost and accessibility measures are growing. The current APCDs and claims databases must be completely retrofitted to accommodate the data requirements these new payment and quality models currently being refined under MACRA. Also, the recent decision of the ***Gobeille v. Liberty Mutual Insurance Company*** case[2] severely impacted the breadth and depth of claims-based data that will be included in the state APCDs moving forward – further eroding the potential for APCD data to be effectively used in assessing population health and cost trends when developing alternative payment models.

Currently CMS collects some level of data via a federated data module using the Edge server technology. Anthem's recommendation is that NCVHS consider recommending a common technical architecture similar to the model used by CMS to facilitate the development of a multi-state, federal claims database architecture that would serve multiple reporting and analytical purposes. Each state/entity would utilize such common architecture to work toward accomplishing the goals of their APCDs.

STANDARDS – EMERGING ISSUES AND CHALLENGES

Current formats in use and future opportunities to standardize reporting formats across states (X12, NCPDP, others).

There have been multiple APCD standards introduced by multiple groups (X12, APCD Council, etc.) and adopted over the last six plus years in an effort to standardize the APCD data elements. Previous efforts toward standardization have yielded a variety of standards which have not resolved the issues with APCD data implementation. Some of these efforts are:

- Core Set of APCD Data Elements developed by APCD Council with input from multiple stakeholders
- ASC X12 PACDR for medical claims reporting developed by American National Standards Institute
- Pharmacy data standards developed National Council for Prescription Drug Programs

Anthem is not endorsing a specific standard at this time, however we are endorsing the need for a single standard that is embraced by all state APCD and claims-database reporting entities. Future opportunities to standardize APCD data reporting need to include:

- Standardizing the underlying technical infrastructure to enable APCD data collection
- Considering the adoption of a federated data model for APCD states/entities
- Standardizing the process by which data is collected or accessible
- Agreement among state APCDs on the data elements which are collected (core data elements)
- A standard process by which data is processed by the APCD entity methodology used to determine data integrity (data quality & data thresholds)
- Agreement on a common frequency of the data collection/access efforts
- Transparency and standardization of the methods and process for aggregating APCD data
- Standard measures, methods and algorithms for reporting APCD data quality and cost measures including the methods used for defining episode groupers, etc.
- Standardizing the APCD data security and privacy practices
- Establishing a uniform data integrity policy that ensures the protection of the data elements that should NOT be released to third parties (group level data, patient identifiers unless masked)

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[2] *Id*.

- Standardizing the format for reporting Payer claims data to the state for Commercial and Medicaid encounter claims data (i.e. ASC X12 PACDR, HL7 resource).
- Defining new reporting requirements to support value-based payments (payments not tied to encounters or episodes of care)

Benefits, efficiencies and barriers, to the adoption of a common Claim-based Databases and APCD reporting standard.

One of the biggest benefits to the adoption of a common Claim-based database and APCD reporting standard for the payer and the state APCD is the economy of reporting claims data the same way to every APCD or Claims-based database across geographies. A uniform model would allow states to regionalize and share the cost for the implementation and maintenance of their claims-based APCD databases, which could ultimately drive down the cost of the claims-based APCDs. A more regional based APCD solution greatly benefits researchers who often want to see data stratified across a larger geographical area. To accomplish this economy of scale, state APCDs would need to:

- Agree upon a set of core data elements including data definitions and the format for data reported for each data element.
- Agree upon the format including headers and trailers for the data extract.
- Agree upon the pre-processing requirements, data thresholds and data quality checks
- Agree upon which data elements are required vs. optional
- Agree upon the inclusion/exclusion criteria for reporting APCD data

Emerging reporting needs to support healthcare transformation and payment reform (e.g., capturing non-claims transactions, data linkage, etc.).

The health care landscape is changing rapidly. Anthem is addressing federal and state initiatives that are introducing changes to risk adjustment models, variable payment models, quality measure reporting and population health reporting. All of these transformational reforms are not adequacy captured by current APCD reporting requirements; for example, APCDs do not presently collect information on clinical, lab, and testing data. The cost of expanding these claims-based databases in their present form would greatly challenge their ability to achieve sustainability, increasing the need to regionalize these APCD databases to spread the cost across a larger population and increase affordability through efficiencies and the removal of duplicative efforts.

Roadmap for achieving standardization and how NCVHS may engage in a supportive role.

Given its role as an advisory body to the Secretary, NCVHS's endorsement of a common APCD technical framework, infrastructure and data model for APCD data reporting would go a long way toward addressing many of the challenges posed by the current lack of standardization. NCVHS can also recommend that adoption of a common APCD technical and data framework be a condition of receiving federal funding to establish/maintain state APCDs (i.e. SIM grants).

Our recommendation would be to establish a multi-state, federated claims data base architecture that would serve multiple reporting and analysis purposes which each state/entity would utilize. This model better supports population health reporting across geographic boundaries.

In summary, Anthem believes NCVHS can play an important role in advancing transparency by promoting the adoption of a common framework/approach for data collection and use and we thank the Committee for this important opportunity to testify on this topic.

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Again, thank you for allowing me the opportunity to testify regarding our perspective on Claims-based Databases for Policy Development and Evaluation. I'd be happy to answer any questions you may have. Should you have later questions, I may be reached at (203) 464-9969, or via email at Sturney@healthcore.com.