Representative Ivy Spohnholz

House Labor & Commerce Committee Chair
House Health & Social Services Committee Vice Chair
House Energy Committee Vice Chair
Serving House District 16: College Gate, Russian Jack, Nunaka Valley, & Reflection Lake

SPONSOR STATEMENT

House Bill 229

"An act establishing the Alaska Health Care Transformation Corporation; relating to an all-payer claims database; and providing for an effective date"

HB 229 would establish the Alaska Healthcare Transformation Corporation (AHTC), an independent, legal authority to manage an All Payer Claims Database (APCD). Health care costs around the United States are increasing at an alarming rate. Alaskan health care costs are increasing at an even higher rate compared to other states. Alaska's health care costs 38% more than the rest of the United States. How can costs be contained while improving health care quality and outcomes across the state? The Alaska Healthcare Transformation Project, a group made up of payers, providers, policymakers, and patient advocates, has been meeting since 2017 to work together on this issue. One of their recommendations was to establish an APCD.

An APCD is an aggregation of health care data. The health care data is a collection of claims data from a comprehensive range of sources such as private health insurers, state employee health benefits programs, prescription drug plans, dental insurers, Medicaid, and more. The value of an APCD is that it allows for analysis and informed decision-making for health care consumers and policy makers. It is also a powerful tool for understanding the health care market. Additionally, analysis of geographic, demographic and other areas of potential disparity can help inform policy assessments and improvements.

Understanding the underlying cost drivers and market pressures of the cost of health care is important to developing policies and solutions. An Alaska Health Care Transformation Corporation tasked with establishing an APCD will provide a foundation for ongoing analysis, development, implementation and support for health care policy. There are 20 states that have an APCD. If passed, this legislation will provide the means to develop health care policies that can improve access and affordability for all Alaskans.

For additional information please contact Christine Marasigan, (907) 465-2696 in the Office of Representative Spohnholz.

Representative Ivy Spohnholz

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SECTIONAL ANALYSIS

House Bill 229

"An Act establishing the Alaska Health Care Transformation Corporation; relating to an all-payer claims database; and providing for an effective date"

Section 1
Legislative Findings and Intent
The costs for health care for Alaska State residents is high. Reasonable access to health care is important and is an economic driver to the economy. The state has struggled with implementing durable health care policy. There is no source of comprehensive health care data to inform policy. This data can be provided by an all-payer claims database. The Alaska Health Care Transformation Project, a cooperative effort involving key stakeholders from across the health care spectrum, concluded that comprehensive and consistent health system-level data is necessary. Establishing a public corporation to create an all-payer claims database will allow for innovation in health care delivery. The intent is to encourage full participation by all parties in the corporation and facilitate greater transparency in the health care sector.

Section 2
Amends AS 18.15 to establish an Alaska Health Care Transformation Corporation.
This section includes the details about the governing body, terms, removal, compensation, quorum, meetings, powers, duties, confidentiality, regulations, budget, and definitions.

Section 3
Transition language regarding the Governor's appointment of the initial voting members.

Section 4
Transition regulations. Directs the Alaska Health Care Transformation Corporation to adopt necessary regulations.

Section 5
Immediate effective date.

For additional information please contact Christine Marasigan, (907) 465-2696 in the Office of Representative Spohnholz.

INVITED TESTIMONY FOR HB 229

- Norm Thurston, Executive Director National Association of Health Data Organizations (NAHDO - Co-founders of the APCD Council)

- Scott, Leitz, Senior Fellow, NORC at the University of Chicago

- Laura Young, Executive Director, Healthe Connect Alaska

- Ralph Townsend, Director, Institute of Social and Economic Research, UAA

- Robin Minard/Elizabeth Ripley, Mat-Su Health Foundation

- Dr. John Cullen, member of the Alaska Academy of Family Physicians

HOUSE BILL NO. 229

IN THE LEGISLATURE OF THE STATE OF ALASKA

THIRTY-FIRST LEGISLATURE - SECOND SESSION

BY REPRESENTATIVE SPOHNHOLZ

Introduced: 1/27/20
Referred: Labor and Commerce, Finance

A BILL

FOR AN ACT ENTITLED

"An Act establishing the Alaska Health Care Transformation Corporation; relating to an all-payer claims database; and providing for an effective date."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

*** Section 1.** The uncodified law of the State of Alaska is amended by adding a new section to read:

LEGISLATIVE FINDINGS AND INTENT. (a) The legislature finds that

(1) the cost of health care for residents of the state is high, and the current increase in health care costs has reached a critical point; from 1991 to 2014, the state's health care cost growth rate has averaged 7.9 percent, while the United States average was 5.9 percent during this period;

(2) reasonable access to health care is important not only to the health and vitality of the state's residents but also as an economic driver essential to the state's economy;

(3) to enact effective health care policy and reform, policy makers should

(A) understand cost drivers and health care market pressures;

(B) encourage the use of efficient and evidence-based practices, with sound decision making rooted in accurate and comprehensive information; and

(C) have access to information about health care utilization, quality, and pricing necessary to evaluate health programs and monitor the success and efficiency of efforts to enhance access, reduce health care costs, and improve both health care quality and population health;

(4) the percentage of the state's residents with a usual source of primary care has remained around 68 percent for the last decade, leaving the state ranked as one of the lowest states in this category;

(5) the state has struggled with implementing durable health care policy, which requires a multi-year effort that exceeds the terms of elected government officials;

(6) health care consumers in the state face a challenge finding reliable, comprehensive, consumer-friendly information on health care cost, service utilization, quality, and pricing;

(7) despite the utility and necessity of reliable and comprehensive health care data with sufficient analytic capacity for policy makers, providers, payers, patients, and researchers, the state lacks a central repository and process for collecting and utilizing health care cost and quality data;

(8) comprehensive health care data can be provided by all-payer claims databases, which are large-scale databases that systematically collect health care claims data from a variety of payer sources and which have been used by many other states;

(9) the Alaska Healthcare Transformation Project is a cooperative effort involving key stakeholders from across the health care spectrum;

(10) the Alaska Healthcare Transformation Project concluded that comprehensive and consistent health system-level data is necessary for policy makers to understand and make informed decisions about the health care market in the state;

(11) establishing a public corporation to create an all-payer claims database to continue the work of the Alaska Healthcare Transformation Project is the next step in improving the state's health care system through informed health care decision making; and

(12) the establishment of a public corporation with a legal existence separate and independent from the state should provide a foundation for ongoing policy analysis,

development, implementation, and support for proven strategies that will allow for innovation in health care delivery.

(b) It is the intent of the legislature to

(1) encourage full participation by all parties in the corporation by exempting activities undertaken, reviewed, and approved by the corporation from state antitrust laws to the extent necessary to accomplish the corporation's goals; the legislature does not intend to exempt agreements among competing providers or carriers or the setting of prices or specific levels of reimbursement for health care services; and

(2) facilitate greater transparency in the health care sector by requiring and encouraging all payers to submit health care data to a centralized repository that complies with P.L. 104-191 (Health Insurance Portability and Accountability Act of 1996) for the purposes of making data-driven health care policy that will serve the interests of citizens in the state.

*** Sec. 2.** AS 18.15 is amended by adding new sections to read:

Article 7A. Alaska Health Care Transformation Corporation.

Sec. 18.15.500. Alaska Health Care Transformation Corporation established. The Alaska Health Care Transformation Corporation is created as a public corporation and an instrumentality of the state in the Department of Commerce, Community, and Economic Development, but with a separate and independent legal existence. The purpose of the corporation is to

(1) collect and analyze existing health care cost and quality data;

(2) create an objective, reliable, and comprehensive central repository of health care information;

(3) provide researchers, policy makers, and the public timely and transparent access to health care information while protecting individual privacy and proprietary data;

(4) enable researchers, policy makers, and the public to make informed health care decisions and reduce unnecessary health care costs.

Sec. 18.15.510. Corporation governing body; term; removal; compensation. (a) The corporation shall be governed by a council consisting of 17 voting members appointed by the governor and four nonvoting members. A voting

member must be a resident of the state.

(b) The voting members consist of

(1) four representatives of health care providers located in the state as follows:

(A) one member who represents a tribal health program;

(B) one member who represents a professional hospital association;

(C) one member who represents a professional medical association; and

(D) one member who represents a professional pharmacy association;

(2) four representatives of health care payers as follows:

(A) one member who represents a self-insured employer or group located in the state that is not engaged in the business of providing health care;

(B) one member who represents an insurance company that holds a certificate of authority issued under AS 21.09;

(C) one member who represents a third-party administrator registered in the state under AS 21.27; and

(D) one member who represents the state in the administration of the medical assistance program established under AS 47.07;

(3) four representatives in health care policy-making positions in the state as follows:

(A) one member who represents a policy-making entity in the area of behavioral health services;

(B) one member who represents a municipality that has health care powers, ownership of and management responsibilities for a hospital, or ownership of and management responsibilities for a community health center;

(C) the director of the division of insurance in the Department of Commerce, Community, and Economic Development or the director's designee; and

(D) the director of the division of retirement and benefits in the Department of Administration or the director's designee;

(4) five representatives of advocates for consumers of health care in the state who are located in the state as follows:

(A) one member who represents a children's advocacy association;

(B) one member who represents a long-term services and supports advocacy association;

(C) one member who represents a health insurance broker or consultant for small businesses or acts as a benefits navigator;

(D) one member who represents a behavioral health advocacy association; and

(E) one member who has experience managing health care privacy issues on behalf of consumers.

(c) Notwithstanding a member's appointment under (b) of this section, the member shall serve the best interests of the state and not those of the member or group the member represents.

(d) The four nonvoting members consist of

(1) one ex officio member of the senate appointed by the president of the senate;

(2) one ex officio member of the house of representatives appointed by the speaker of the house of representatives;

(3) one ex officio member representing the Office of the Governor; and

(4) one ex officio member representing the Veterans Health Administration in the United States Department of Veterans Affairs.

(e) When appointing a voting member to the council, the governor shall consider an individual's competence and experience or expertise in the health care industry. The governor shall fill a vacancy in the voting membership of the council after the governor has considered a list of nominees submitted by the council. The governor may reject a list or a portion of a list submitted under this subsection and

request that the council submit another list. The governor shall make the appointment within 45 days after the council submits the list of nominees.

(f) The voting members of the council shall annually elect a chair and vice-chair from among the voting members. The chair and vice-chair may not be members of the same group of voting members as described in (b)(1) - (4) of this section.

(g) Voting members of the council are appointed to staggered five-year terms, may be reappointed, and may not serve more than two consecutive terms. Except as provided in AS 39.05.080(4), a council member appointed to fill a vacancy holds office for the balance of the unexpired term.

(h) The governor may remove a voting member only for good cause. A removal by the governor must be in writing and must state the reason for the removal. The council may suggest to the governor the removal of a voting member. In this subsection, "good cause" means

(1) a violation of AS 39.52 (Alaska Executive Branch Ethics Act);

(2) a conviction of a felony in any jurisdiction; or

(3) a conviction of a misdemeanor in any jurisdiction if the misdemeanor involves dishonesty or a breach of trust or is a crime against the state.

(i) Council members serve without compensation but are entitled to per diem and travel allowances authorized for boards and commissions under AS 39.20.180.

Sec. 18.15.520. Quorum. (a) A majority of the voting members of the council constitutes a quorum for the transaction of business and the exercise of powers and duties of the council. Action may be taken and a motion or resolution may be adopted upon an affirmative vote of a majority of the voting members.

(b) The council may meet and transact business by electronic media. An action taken at a meeting held by electronic media under this subsection has the same legal effect as an action taken at a meeting held in person.

Sec. 18.15.530. Meetings. The council shall meet at least twice every year. A meeting of the council shall occur at the call of the chair or upon the written request of a majority of the voting members of the council.

Sec. 18.15.540. Powers of the corporation. The corporation may

(1) make, use, and alter a corporate seal;

(2) enter into contracts;

(3) establish and amend bylaws;

(4) procure facilities;

(5) employ and determine the salary of an executive director; the executive director may, with the approval of the council, select and employ additional staff as necessary; an employee of the council, including the executive director, may not be a member of the council; the executive director and the other employees of the corporation are in the exempt service under AS 39.25;

(6) solicit, receive, and administer funds from public and private sources;

(7) review and make recommendations on public and private health care quality and performance measurements to ensure efficiency, cost-effectiveness, transparency, and informed choice by consumers and public and private purchasers;

(8) except as prohibited under federal law, require a health care insurer operating in the state to submit health care data to the corporation by a procedure and in a format established by the corporation in regulation; the regulations must require that a health care insurer submit health care data in accordance with AS 45.48 and federal privacy requirements for the protection of patient data; in this paragraph, "health care insurer" has the meaning given in AS 21.54.500 and also includes a third-party administrator of a health insurance plan offered by a self-insured employer or health trust in the state and Medicare and Medicaid plans;

(9) establish an incentive program to facilitate the timely and accurate reporting of health care data;

(10) establish and impose reasonable penalties necessary to ensure compliance with mandatory health care data reporting requirements adopted by the corporation in regulation;

(11) establish agreements for voluntary reporting of health care data, including cost and quality metrics from health care payers that are not subject to mandatory reporting requirements, to ensure availability of the most comprehensive and system-wide data on health care costs and quality;

(12) in collaboration with regionally based stakeholders, incorporate

regional health care agendas and priorities through planning processes and policies that are based on comprehensive health care data;

(13) evaluate a statewide health care cost growth rate based on total health care expenditures as a per capita measure of total health care spending growth;

(14) analyze emerging health policy issues and regulations by working with national and state experts to bring best practices and new ideas to the state;

(15) develop and analyze health and administrative policy on priority topics, such as the key elements of health system transformation, rural health care initiatives, health care financing, and others;

(16) request and be entitled to receive from any department, division, board, bureau, commission, or agency of the state the assistance and data that will enable it properly to carry out its powers and duties; and

(17) carry out other activities necessary to fulfill the purposes of AS 18.15.500 - 18.15.595.

Sec. 18.15.550. Duties of the corporation. The corporation shall

(1) establish policies, procedures, and regulations for the

(A) selection of nominees to the council;

(B) collection, processing, storage, analysis, use, and release of existing health care data in the state, including quality metrics and claims data as specified in (4)(B) of this section, beginning with the establishment of an all-payer claims database;

(2) develop strategies to steer the health care system in the state toward a population-based payment and delivery system, beginning with uniform reporting of a core set of health care quality measures;

(3) provide policy analyses and programming recommendations for health policy leaders in the legislative and executive branches of state government and those in the public and private sector concerned with improving the value of health care in the state;

(4) establish a statewide all-payer claims database that provides

(A) publishable analytics that improve transparency so as to

(i) assist patients, providers, and hospitals to make

informed choices about care;

(ii) enable providers, insurers, payers, hospitals, and communities to improve by benchmarking their performance against that of others and focusing on established best practices;

(iii) enable purchasers to identify value, build expectations into their purchasing strategy, and reward improvements over time; and

(iv) promote competition based on quality and value;

(B) systematic collection of, at a minimum,

(i) payment and other data for all medical and pharmacy claims that are billed, rejected, and paid;

(ii) payment and other data for all health care-related claims that have been adjudicated;

(iii) de-identified enrollment files and provider files that include cost and quality metrics from private and public payers, with data from all settings of care that permit the systematic analysis of health care delivery;

(C) enhanced transparency and accountability and validated statewide, plan, and health care entity-level data by market segment, health care setting, demographics, geography, diagnosis, and other variables;

(5) use a competitive bid process under AS 36.30 (State Procurement Code) to select an organization to coordinate and manage the all-payer claims database;

(6) establish a data policy advisory committee to provide input on data collection, data security, data de-identification, reporting, data release policies, development of data release procedures, formal data release requests, and related policies; the advisory committee must include representatives of provider and consumer groups, health care purchasers, health plans, health care researchers, and state agencies involved in implementation of the all-payer claims database;

(7) develop a data submission guide with input from stakeholders and design a process that will allow for stakeholder review and comment on drafts of the

data submission guide and all subsequent changes to the guide; the data submission guide must, at a minimum, establish data submission requirements, including required fields, file layouts, file components, editing specifications, instructions, and other technical specifications;

(8) approve the data submission guide and all subsequent changes;

(9) establish committees to provide for stakeholder engagement, including

(A) a proposal evaluation committee to review proposals, including for data management services;

(B) an advisory committee on social determinants of health to provide input into developing measures of social determinants of health; and

(C) an advisory committee on health care quality measures to provide input on a core health care quality measure set;

(10) analyze health care data to support informed health policy and health reform efforts;

(11) identify and explore key health care issues, questions, and problems that may be addressed through more transparent, objective, reliable, and comprehensive health care data;

(12) compare the cost and effectiveness of various treatment settings and approaches;

(13) address emerging health care issues and topics as they arise in the future;

(14) provide information to consumers and purchasers of health care relating to the cost and quality of health care services;

(15) identify sustainable funding strategies for funding ongoing operations from both public and private sources; and

(16) use a competitive bid process under AS 36.30 (State Procurement Code) to select an organization to design, build, and maintain the all-payer claims database website.

Sec. 18.15.560. Confidentiality. The all-payer claims database and the information contained in the database are confidential and not public records subject

to public inspection or disclosure under AS 40.25.100 - 40.25.295 (Alaska Public Records Act). The organization selected to coordinate and manage the all-payer claims database under AS 18.15.550(5) shall ensure the security and confidentiality of the database and the information contained in the database. Aggregated health care information contained in the database may not be shared except as provided in regulations of the corporation. Individually identifiable health care information contained in the database may be accessed only by the organization selected to coordinate and manage the all-payer claims database under AS 18.15.550(5) and may not be shared.

Sec. 18.15.570. Regulations. The corporation may adopt regulations under AS 44.62 (Administrative Procedure Act) to carry out its duties.

Sec. 18.15.580. Budget. The operating budget of the corporation is subject to AS 37.07 (Executive Budget Act).

Sec. 18.15.595. Definitions. In AS 18.15.500 - 18.15.595,

(1) "corporation" means the Alaska Health Care Transformation Corporation established under AS 18.15.500;

(2) "council" means the governing body of the corporation.

*** Sec. 3.** The uncodified law of the State of Alaska is amended by adding a new section to read:

TRANSITION: MEMBERS OF THE COUNCIL OF THE ALASKA HEALTH CARE TRANSFORMATION CORPORATION. Notwithstanding AS 39.05.055 and AS 18.15.510(e) and (g), added by sec. 2 of this Act, the governor shall, not later than 90 days after the effective date of this Act, appoint the initial voting members of the council of the Alaska Health Care Transformation Corporation to one-year terms. The governor shall use the criteria in AS 18.15.510(b) and (d), added by sec. 2 of this Act, when appointing the initial members of the council.

*** Sec. 4.** The uncodified law of the State of Alaska is amended by adding a new section to read:

TRANSITION: REGULATIONS. (a) Not later than June 30, 2021, the Alaska Health Care Transformation Corporation shall adopt regulations necessary to implement AS 18.15.550(1), enacted by sec. 2 of this Act. The regulations take effect under AS 44.62

(Administrative Procedure Act), but not before the effective date of sec. 2 of this Act.

(b) Not later than December 31, 2021, the Alaska Health Care Transformation Corporation shall adopt regulations necessary to implement AS 18.15.550(5), enacted by sec. 2 of this Act. The regulations take effect under AS 44.62 (Administrative Procedure Act), but not before the effective date of sec. 2 of this Act.

*** Sec. 5.** This Act takes effect immediately under AS 01.10.070(c).

Alaska Healthcare TRANSFORMATION PROJECT

FROM PROJECT TO POLICY

Since 2018, the Alaska Transformation Healthcare Project has been working to transform Alaska's healthcare system. Payers, providers, policymakers, and patient advocates came together to assess Alaska's current system and identity opportunities to improve access and affordability for all Alaskans. This public-private Project was funded by the State of Alaska, Rasmuson Foundation, the Alaska Mental Health Trust Authority, and the Mat-Su Health Foundation.

The Project's recommendations have been incorporated into new legislation that if passed, will truly transform Alaska's healthcare system by establishing the Alaska Healthcare Transformation Corporation to develop and manage an all-payer claims database to guide healthcare policy and decisions for generations to come.

LEGISLATION AT-A-GLANCE

TITLE: **An Act establishing the Alaska Healthcare Transformation Corporation; relating to an all-payer claims database; and providing for an effective date.**

SPONSOR: **Representative Ivy Spohnholz**

FINDINGS & INTENT:

1. Already high healthcare costs for Alaskans continue to increase at an alarming rate compared to other states.
2. Reasonable access to health care is critical for all Alaskans and is an economic driver essential to Alaska's economy.
3. Understanding the underlying cost drivers and market pressures of Alaska's high cost of care is essential to developing policies and solutions.
4. To date, policymakers have not had the data to attain a comprehensive understanding of these contributing factors.
5. Establishing an all-payer claims database would finally provide the critical information needed to understand and transform Alaska's health care system.
6. Establishing the Alaska Healthcare Transformation Corporation would create an independent legal authority to manage the all-payer claims database and provide the means to develop healthcare policies that will improve access and affordability for Alaskans.

AKHEALTHCARETRANSFORMATION.COM

SANDRA HEFFERN, PROJECT COORDINATOR
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2019 ACCOMPLISHMENTS

COMPLETED the background research for the Project through the contractor NORC at the University of Chicago. Produced four reports:

Alaska Historical Project Scan. Identified and assessed selected delivery system reform experiments in Alaska over the past decade (2008 to the present), with priority to characterizing regional innovation within the state.

Alaska Studies–Meta-Analysis. Identified and assessed a group of Alaska-focused reports and studies issued over the past decade (2008 to the present) that concern health reform.

National Scan. Developed case studies for selected states where delivery system reform relevant to Alaska's five key topics of interest offers lessons for prospective innovation.

Drivers of Health Care Costs and Spend in Alaska. Reviewed health care spending in the state and provided an assessment of the data available to support a fine-grained analysis of cost drivers. Proposed recommendations of options for reforms that would likely reduce costs.

KEY FINDINGS:

Alaskans have spent tremendous time, energy, and commitment studying healthcare issues in the state with very few examples for evidence based practices that can be generalized to larger populations or used to increase access to high quality healthcare at sustainable costs.

Other states further on the path towards reforming their healthcare systems have begun by having a clear understanding of their healthcare claims information. Alaska does not have a centralized repository for healthcare claims data which has made it difficult for us to truly analyze the healthcare cost drivers and utilization patterns.

The collection and analysis of multi-payer health data, inclusive of both claims and quality information, will play a vital role in helping to fill critical information gaps, promote healthcare transparency initiatives, and provide policymakers with access to accurate data to drive healthcare policy.

DEVELOPED:

Details, parameters, and building consensus around the collection of cost and quality data and ensuring sufficient analytic capacity to effectively analyze and use the data.

Multi-payer goals for value-based payment

The structure and responsibilities of the leadership governance

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California Health Care Foundation

November 2018

Issue Brief

The ABCs of APCDs: How States Are Using Claims Data to Understand and Improve Care

All-payer claims databases (APCDs) systematically collect administrative data, including medical, pharmacy, and dental claims, eligibility files, and provider (physician and facility) files. These claims are created when an insured patient receives care or fills a prescription, and include a record of what was provided, who provided it, how much was charged, and how much was paid. In capitated systems like Kaiser Permanente, these data are generated when a patient has an encounter with the care system. Data are submitted directly from health insurers, third-party administrators, and pharmacy benefit managers to a central point, often a state agency or its vendor.

Fourteen states currently have functioning APCDs, and another 10 are in various stages of development. In June 2018, Governor Jerry Brown signed AB 1810, which set aside $60 million in state funds for the creation of an APCD in California.

States have a long history of collecting, analyzing, and reporting health care data for assessing quality and system performance. Hospital discharge and financial databases, such as those maintained by the California Office of Statewide Health Planning and Development, have provided systemwide information on hospitals for decades. A statewide APCD could provide more broad information on the use and price of care across different settings. This information could be used by policymakers, health care providers, plans, employers, and academic researchers to understand regional variation in care delivery and price, monitor population health trends, and ensure patients have adequate access to care. Several states have created transparency tools for consumers using APCD data.

This issue brief provides examples of the ways APCDs are being used by selected states and illuminates issues of critical importance to California, including health care and prescription drug spending trends, opioid use and prescribing patterns, and the prevalence of chronic disease. It concludes with a short summary of key areas for consideration when developing a new APCD. More information on these issues and other use cases for APCDs can be found at www.apcdshowcase.org.

Tracking Spending Trends and Cost Drivers

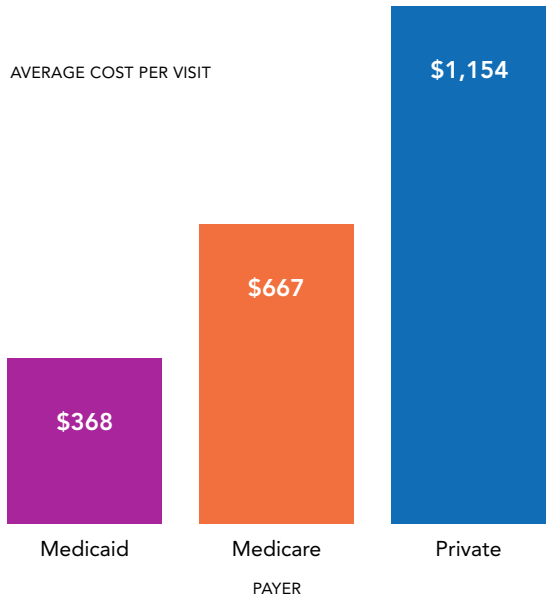
Numerous states are using their APCDs to understand statewide spending trends and health care cost drivers. Massachusetts's APCD is used by the state's Health Policy Commission to create an annual report that examines trends in health care spending for commercial payers by category of service (e.g., hospital outpatient, inpatient, and emergency department), type of episode (e.g., MRI, colonoscopy), and geographic area. These data are used each year to make policy recommendations about how to meet spending growth targets in Massachusetts.

Rhode Island used its APCD to uncover the top 15 symptoms of patients presenting to the state's emergency rooms, as well as the associated costs of potentially avoidable emergency room visits broken down by payer type (e.g., Medicaid, Medicare, private insurance) (see Figure 1). The analysis suggests there is $90 million in potential savings to the state in reducing avoidable emergency room visits.

Minnesota used its ACPD to produce a series of reports that focuses on the variation in prices for four common, high-volume hospital inpatient treatments. Researchers found two- to seven-fold differences in the prices for those procedures within hospitals for commercially insured patients. These differences persist after controlling for factors such as clinical complexity and length of stay. Such information could allow self-insured employers, health plans, and hospitals to further investigate and ultimately reduce variation in price.

Finally, the APCD in Virginia was used to study health care spending for "low-value services" as defined by the Choosing Wisely® initiative and other national initiatives that focus on preventing unnecessary medical tests and procedures. Researchers identified $586 million in unnecessary spending for 44 low-value services.

Figure 1. Cost of Potentially Avoidable Emergency Room Visits, Rhode Island, 2013–2014



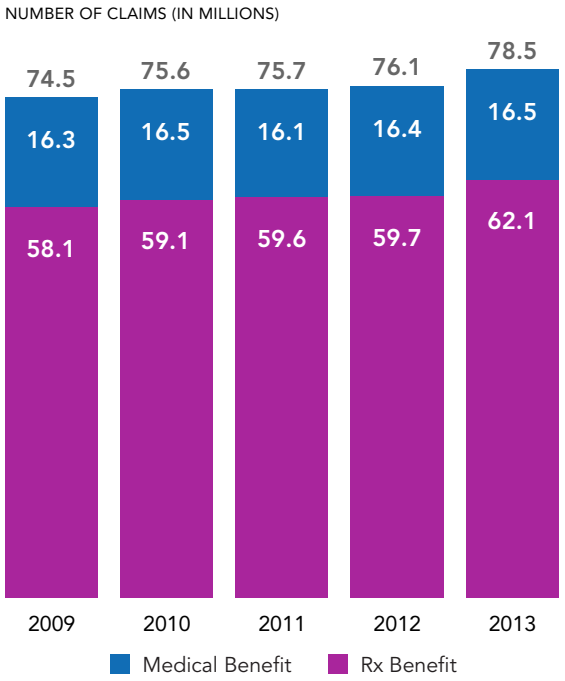
Source: *Potentially Preventable Emergency Room Visits*, Rhode Island Dept. of Health, health.ri.gov.

Understanding Prescription Drug Spending and Use

Minnesota's APCD has been used to analyze prescription drug spending by therapeutic category and setting, highlighting how spending on prescription drugs is split between medical and prescription drug benefit plans (see Figure 2). The research shows that more than a third of prescription drug spending in the state was covered through medical benefits, an often overlooked and opaque component of total health system spending.

Analysis of the Colorado APCD by the Center for Improving Value in Health Care (CIVHC) showed the increase in median price for EpiPen prescriptions for both commercial and Medicaid plans. The median amount paid for EpiPen prescriptions increased from just over $100 to $500 between 2009 and 2016. Having access to these data can help media, advocates, and others raise awareness of these price increases, and support initiatives to lower the costs for necessary drugs.

Figure 2. Spending on Prescription Drugs in Minnesota, 2009–2013



Source: *Prescription Drug Spending Trends in MN*, Minnesota Dept. of Health, Feb. 29, 2016, www.health.state.mn.us (PDF).

Uncovering Key Drivers of the Opioid Epidemic

State APCD systems in Virginia, Utah, and Minnesota have used data from their APCDs to track opioid prescription claims across geographic areas and patient characteristics to understand and address trends in the epidemic. One study in Utah analyzed the diagnoses for which people were prescribed opioids (see Table 1). The study showed that back pain was the most common condition for which chronic users were being prescribed new opioid medications, information that can be used to target physician outreach.

Table 1. Top Diagnosis Categories (CCS) at Initial Prescription for Chronic Users, Utah July 1, 2014, to June 30, 2015

	NUMBER / PERCENTAGE	
Spondylosis; intervertebral disc disorders; other back problems	323	27.2%
Other non-traumatic joint disorders	71	6.0%
Other connective tissue diseases	67	5.6%
Medical examination/evaluation	58	4.9%
Headache, including migraine	56	4.7%
Osteoarthritis	44	3.7%
Other nervous system disorders	42	3.5%
Essential hypertension	42	3.5%
Diabetes mellitus without complication	30	2.5%
Rheumatoid arthritis and related disease	26	2.2%

Source: *Utah Health Status Update: Initial Diagnosis of Opioid Naive Patients*, Utah Dept. of Health, Sept. 2017, ibis.health.utah.gov (PDF).

The Minnesota Department of Health used its APCD to provide the legislature with information on opioid prescribing patterns and to inform the development of new practice guidelines. The analysis focused on the use of high-dose opioid prescriptions and showed that back pain and chronic pain accounted for almost a third of high-dose opioid prescriptions in 2015, as shown in Table 2.

Table 2. Proportion of Prescriptions by Prior Procedure or Diagnosis, 2015

PROCEDURE OR DIAGNOSIS (WITHIN 90 DAYS)	TOTAL	HIGH-DOSE (90+ MME PER DAY)
Surgery	51.7%	50.7%
Injury	7.3%	5.7%
Back pain	9.4%	12.2%
Other acute pain	1.0%	1.0%
Other chronic pain	13.0%	18.2%
Long-term opioid use	1.0%	1.1%
Other medical visit	7.4%	4.0%
No medical visit	9.3%	7.1%

Source: Stefan Gildemeister, *Opioid Use in Minnesota: Analysis of Prescribing Patterns & Chronic Use* (presented at annual meeting of the National Association of Health Data Organizations, Oct. 2018), Minnesota Dept. of Health, Oct. 11, 2018, www.nahdo.org (PDF).

Estimating the Prevalence and Cost of Chronic Disease

APCDs have been valuable sources of information to describe important public health issues, including prevalence reports for chronic conditions. In Colorado, CIVHC analyzed data from its APCD to provide estimates of the population with diagnoses of hypertension and diabetes (see Figure 3) in Medicaid, Medicare, and commercially insured populations. The report also showed the change in disease prevalence over time.

Virginia also released a summary review of chronic condition prevalence and cost in the state (Figure 4), finding the overall cost for people with at least one of the state's five most prevalent chronic conditions (see sidebar) was four times higher than for those without. Such information could be useful in targeting public health campaigns around certain conditions and geographic areas.

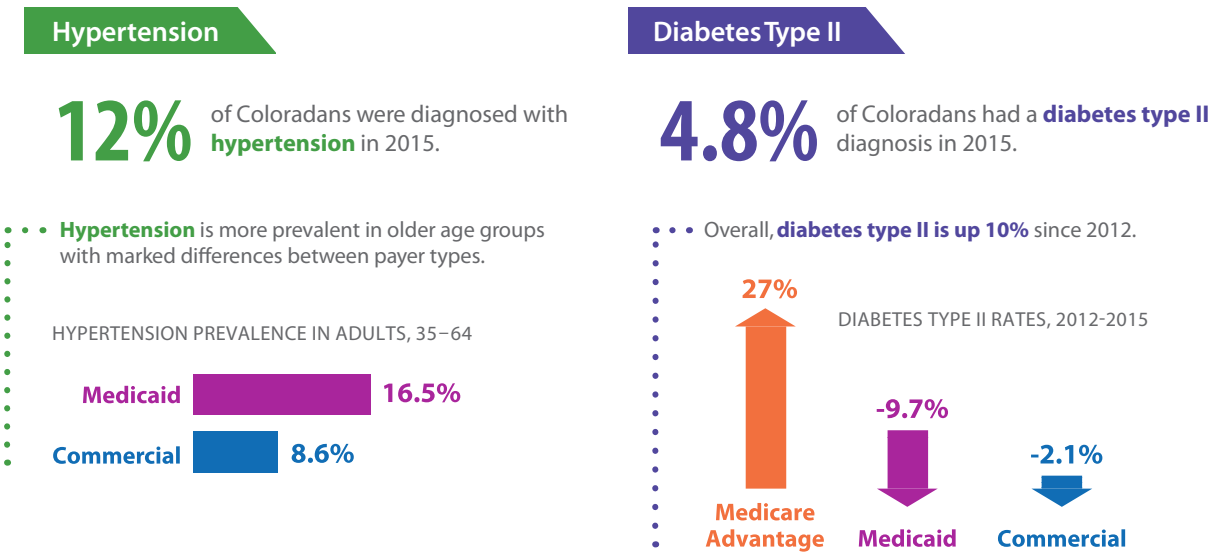
Top Chronic Conditions, Virginia, 2015*

- Hypertension
- Asthma
- Diabetes without coronary artery disease
- Chronic musculoskeletal disorders
- Gastrointestinal disorders

*Accounted for more than 50% of individuals with a chronic condition.

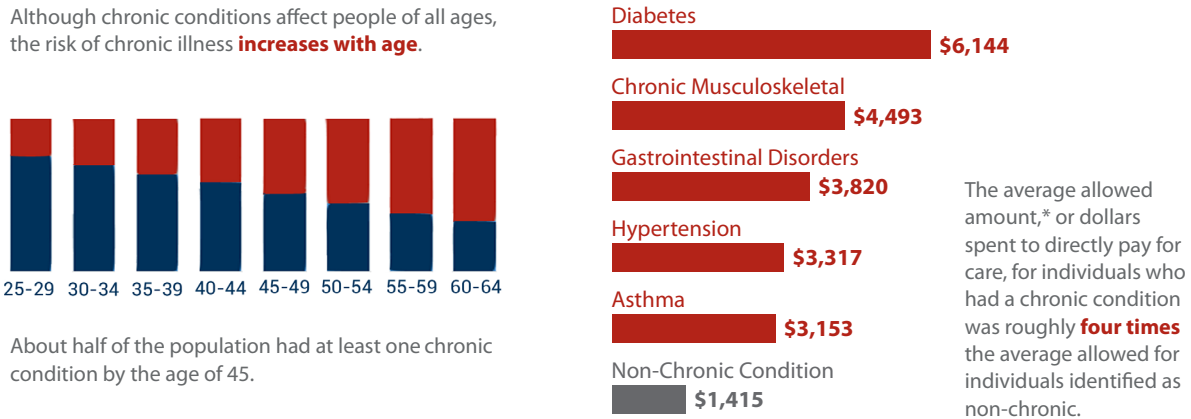
Source: *Chronic Conditions in Virginia*, Virginia Health Information, www.vhi.org (PDF).

Figure 3. Chronic Condition Insights, Colorado, 2015



Source: *Chronic Conditions in CO*, Center for Improving Value in Health Care, www.civhc.org (PDF).

Figure 4. Top Chronic Condition Prevalence in Virginia, 2015



*Displayed using standardized proxy reimbursement amount.

Source: *Chronic Conditions in Virginia*, Virginia Health Information, www.vhi.org (PDF).

Designing for Success: Six Key Areas

Throughout the past 15 years of APCD development, states have identified six key components for conceptualizing and implementing a database that can produce useful information for policymakers, public health officials, health care providers, plans, consumers, and other stakeholders. Summarized below, these components include engagement, governance, funding, technical build, analysis and application development, and continuous feedback.

More information on each component is accessible in the APCD Development Manual available at www.apcdcouncil.org. Each component of the development cycle is interdependent on the others and all need to be considered to ensure success.

- **Stakeholder engagement** is the foundational step in the development of an APCD. It is critical for articulating and communicating the purpose of the APCD. Stakeholders typically are key users of the system, and their buy-in and support is important throughout the entire development cycle. Establishing a shared vision and purpose for the system informs the requirements and guides decisions around other key components. States can cultivate a strong community to support APCD development through this inclusive and deliberative process, which requires continual feedback to grow the system over time.
- **Governance** covers the legal framework, including authorizing legislation, and designates the oversight entity and oversight structure (e.g., advisory board or governing commission). These components form the foundational structure of the APCD and have bearing on all aspects of the technical build and use of the APCD. Governance structures can drive or limit the functionality of the other components. The final governance parameters (in legislation, rules, and policies) will reflect the state's intended use of the data, political environment, oversight of the system, and assurances for privacy and data use.
- **Funding** for initial development and sustainable operations of the APCD has an important impact on the approach to the technical infrastructure and scope of analytics. States use various funding mechanisms for initial and ongoing system support. Diversification of revenue sources is recommended for long-term sustainability. Because there is value to the systemwide, cross-payer data that are captured in an APCD across multiple state agencies (e.g., health departments, insurance departments, Medicaid), states have been successful in leveraging funds across state and federal agencies to support the system.
- The **technical build** is the data infrastructure of the system. It begins with data submission requirements and includes the data intake and quality control / data management protocols that are used to validate and aggregate the data. The technical build phase of APCD development results in the operational and quality assurance protocols for receiving and processing the data that will be used for analytics and applications. Because many states use a vendor for these functions, it is important to issue a clear and complete request for proposals to assure intended results and functionality of the system.
- **Analysis and application development** decisions are driven by stakeholder information needs and are tied to the governance and oversight structure of the APCD. By focusing on analytic utility, a broad range of options exist for the state to make the data available, including releasing reports, creating online analysis tools, and developing analytic data sets for external users. A comprehensive analytic plan with a transparent and open process for providing data at various levels of detail for key users can help assure that APCD data are used appropriately.
- **Continuous feedback** is critical to improve each component of the data development cycle and to add value to the information the system generates. States that have invested in building strong stakeholder processes have forums to deliberate the many challenges faced during each phase of system development and deployment. As APCD programs and systems mature, stakeholders provide input for enhancements that drive the ultimate value of the information produced.

Conclusion

A statewide APCD reporting system provides unique opportunities to examine the performance of the health care system, providing a wide-angle lens on patterns of care, costs, and covered populations that includes multiple payers and types of providers. Having this type of independent, systemwide data helps uncover information, such as the underlying drivers of health care costs, understanding the prevalence and impact of public health issues like chronic disease, and informing policies around opioid prescribing guidelines. Using a six-part framework for conceptualizing and implementing a statewide APCD can lead to the creation and implementation of a database that produces useful information for all of California's important health care stakeholders.

About the Authors

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About the APCD Council

The APCD Council is a learning collaborative of government, private, nonprofit, 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 at the University of New Hampshire and the National Association of Health Data Organizations. The council's work focuses on shared learning among APCD stakeholders, early-stage technical assistance to states, and catalyzing states to achieve mutual goals. For more information, visit www.apcdcouncil.org.

About the Foundation

The California Health Care Foundation is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford.

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

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