

**NY All Payer Database
12/9/15 Stakeholder Forum
Summary of Question & Answer Sessions**

This summary highlights the main points of stakeholder questions and panel answers. It attempts to best summarize the exchanges for reference for all stakeholders, and does not represent a verbatim transcript.

Topic – Completeness of APD Data Set (i.e., Self-Pay and Self-Insured Data Gaps)

Q – From Health Care Researcher

With regard to both operations and governance of the APD, how are self-pay consumers being addressed? Are self-pay services being captured? If not, what is the impact on the quality of the data?

A - Self-pay data (i.e., paid out-of-pocket w/ no insurance) will not be captured as there is not currently a way to collect data that is not claims based. DOH has no authority to collect APD data directly from providers. The only authority is to collect from payers.

Q – Will the APD try to “estimate the error”, or otherwise adjust for the lack of self-pay data, within the data set?

A – There is not a definitive answer or approach at this time. Right now, the focus is on successful collection and validation of the claims based data that the APD has authority to collect. As much as possible, the lack of self-pay data will be taken into consideration when analytics are run on the data set.

Q – Of particular concern is communicable disease data. The fear is that if the APD will replace data collection from public health registries, and if the APD data lacks self-pay (viewed as significant to researchers), the value of the registry data will be diminished.

A – The APD will not “replace” public health registries. Some registry data is currently collected via claims, and that particular data collection may look to the APD instead, so as not to duplicate effort. Other non-claim registry data will continue to be collected, however. The APD is envisioned to supplement and enhance registry data, not replace it.

Q – Why can’t there be a legislative initiative to mandate submission of data by providers, so that the gaps in self-pay and self-insured care can be eliminated.

A – In theory, legislation could be initiated to close these data gaps. It would result, however, in a distinctly new direction of the project, from the current focus on collection of post adjudicated claims data, which covers the majority of those receiving care in the state. There are some additional existing data sets that the APD plans to either incorporate or connect to that will capture some of the information from self-pay individuals, including SPARCS, SHIN-NY, and various public health registries. They will not include paid claims information, however.

Q – What about self-insured employers / self-funded plans?

A – DOH is closely following the progress of a U.S. Supreme Court case, originating in Vermont, where an employer challenged the mandatory collection of APCD claims data from self-funded plans as a violation of federal ERISA law. In that case, a ruling is expected in the summer of 2016 that will impact all states efforts to potentially collect data from these plans. DOH will be monitoring the outcome closely to see how it impacts our ability to mandate data collection. In the meantime, voluntary data submission by self-funded plans is being explored. Some states

have had a degree of success with voluntary submission to date, and New York has had some positive feedback from some self-funded plans already. Needless to say, if self-funded plan data collection cannot be mandated, there will be a gap in data collection.

Topic – Planned Data Collection - Health Benefit Exchange Essential Health Plans and Commercial Health Plans

Q – From Health Plan

What are the plans and timing for collection of NYSoH Essential Health Plan and Commercial Health Plan data?

A - Essential Health Plans (EHP) are scheduled to begin coverage in January 2016. The APD team is currently working with the intake vendor (CSC) to build the capability to identify and validate EHP information that will be coming in. We anticipate that data will begin to be reported in the 1st quarter of 2016. For the Commercial Plans, there is a need for the new APD regulations to be further along in order to fully elaborate the mandate and mechanism for submission, to ensure plans submit data to test the system. Without the regulatory authority, claims volume isn't expected to be high enough to stress the system enough to test it (QHP, EHP and Medicaid Managed Care all have existing authority to collect encounters via contracts with DOH). In addition, the data intake system needs development work to provide for submission of a new enrollment transaction, which has not had to be done to date for the other plans (i.e., QHP and Medicaid Managed Care). The expectation is that regulations and commercial data collection will both develop in 2016.

Q - Why is EHP data submission on a different timeline than QHP? Is there something inherently different between the two plans?

A – No, the data intake specifications are the same for QHP and EHP. Because the EHP program is new in January, however, we don't expect data to be flowing immediately. The expectation of data intake commencing in 1st quarter 2016 allows for a period of testing and gradual on-boarding of plans, plus claims lag for provider visits just commencing in January.

Topic – Data Validation and Continued Value to Current Users

Q – From Health Care Researcher

On the production/analytics side of the APD, will there be value added data, such as reclassification of data based on what is collected (e.g., episodes of care, bundled payments, reclassification to identify cohesive groups)?

A – Yes. There are existing value add analyses that are done on Medicaid data that will continue to be done with the APD, such as risk grouping and avoidable hospitalizations. There are also new analyses that we envision, such as new groupers and bundled care. The APD data warehousing and data analytics contract includes provisions for both continuation of existing value added data and new analyses. Bundled payments will be an area that is an acknowledged challenge to incorporate, is important to the value and utility of the APD, and will need to be addressed carefully with payers as the system design continues.

Q – From Health Plan

There are health plan concerns about current processes, such as data used from MEDS III, and how they will use data from the APD to perform analysis such as risk adjustment. Will they still

have access to the same information for these reviews and analyses, and will the data be comparable between the systems?

A – There have always been transitions over time with respect to Medicaid data reporting and validation (e.g., ICD-9 to ICD-10). As much as possible, data formats and structures are kept consistent (e.g., core format of MDW data remains with APD development). The APD will undertake careful analysis to ensure data quality and validity, understanding that it will be used for many critical activities and tasks.

Q – Will there be transparency and open dialogue with health plans as these transitions occur to ensure all data collection issues are addressed?

A – Yes, the APD team has weekly webinars that are open to all issuers to monitor progress of data collection efforts and to troubleshoot any issues that arise. Active participation by all issuers is strongly encouraged.

Topic – Project Timing & Payer Responsibilities

Q – From Health Plan

In reference to slide #35 (APD Infrastructure Diagram), what future work should plans expect to dedicate resources to the APD releases. It is clear that QHP (release 1) and Medicaid Managed Care (release 2) have been rolled out, and the APD team has stated Commercial (release 3) is planned for late 2016. What about the box indicating Medicaid FFS Encounters?

A – Medicaid Fee-for-Service encounters will not require additional resources or testing from health plans. That data is currently collected by the State’s Medicaid vendor, and will eventually be transmitted to the APD for incorporation to the database. This doesn’t mean there will not be future enhancement and evolution work with data collection and that may require attention by plans.

Topic – Submission of Supplemental Transactions by Plans

Q – From Health Plan

How do new APD submission requirements impact supplemental transactions? Is there a mechanism for insurers to submit additional information?

A – Yes, the APD will accept supplemental transactions, providing that they are in PACDR format. Plans are welcome to explore the topic in further detail at the weekly issuer webinars.

Topic – Planned APD Consumer Facing Website

Q – From Consumer Advocate

Slide #43 references a consumer facing website as part of the Data Warehouse & Data Analytics contract. What is the vision for this website? Will the “consumers” it will be geared towards be researchers or patients?

A – Additional information will be presented in a subsequent portion of the presentation. In reference to the basic question, the website focus is envisioned to encompass all consumers, inclusive of those seeking tools to make informed health care decisions, as well as those conducting health care research.

Topic – Data Release Governance

Q - Slide 58 provides information about proposed governance structure and process. Specifically, it states a leaning toward an “internally designated committee” to review data release requests. What does that mean to the data release process, and how does it relate to the previous APD Steering Committee that existed?

A – The internally designated committee would mean members are appointed by DOH to the role. We will need to develop a process to publicize how people become aware of and receive nomination, and will be part of a data release policy currently under development. The internally designated committee is less formal and structured than an official public board. With respect to the former APD Steering Committee, that entity’s function evolved over time so that it most recently was simply a large listserv to disseminate information and not functioning at full capacity as originally formed. The proposed APD regulations will likely provide for the opportunity to have multiple advisory committees to address specific portions of the APD operations.

Q – From Health Care Researcher

With regard to release of confidential data. Would DOH envision utilizing Institutional Review Boards (IRBs) as a part of the review process?

A – Yes, IRB involvement is something that would be considered as having a potential role in administering the data release process.

Topic – Stakeholder Categories / Groups

Q – Are there formal categories for stakeholder groups? There doesn’t appear to be a category for labor unions, which is one that could benefit from access to price and quality data.

A – APD stakeholder groups are generally listed as including payers, providers, employers, researchers, consumers, and policy makers. This is not necessarily an inclusive listing, however, and the identification of labor unions is a good one. In many ways, they appear similar to employers in that they provide/negotiate employee benefits. While not specific to labor unions, we have had some interaction with representatives of NYSHIP, which administers employee benefits for unions representing NYS employees.

Topic – Use of APD for Analysis of Health Care Quality

Q – How does the APD relate to the current system of collecting data to measure quality, such as HEDIS and QARR measures? Will DOH be moving to the APD as a sole measure of quality & value?

A – There are no plans to discontinue collection and use of HEDIS and QARR data for quality measurement. However, the APD will be used as an additional tool to enhance quality measurement.

Topic – Pricing Data – How Detailed Will the APD Get?

Q – From Health Care Researcher

How will the APD address costs vs. pricing models vs. actual payment amounts? There is mention of aggregating to median pricing. Will DOH consider including other tools such as dispersion measure, median absolute deviation (MAD), or other statistics around the distribution of pricing?

A – We will definitely explore multiple tools, however, there is a priority on protecting a certain level of confidentiality of payer to provider price information (which is the rationale behind the proposed use of median price). We will be cautious in terms of how many elements are put together, so as not to inadvertently allow for determining granular pricing data intended for protection.

Topic – Value Based Payments – How Have Other States Addressed?

Q – From Health Plan

How have other states tried to address the issue of capturing value based payments or supplemental payments that aren't reported at the claims level?

A - (from APCD Council) - The issue of how to effectively capture such payments, particularly when analyzing total cost of care, is very important and at the same time challenging. To date, Massachusetts and Maryland have done significant work investigating better ways to capture that information. Other states typically receive external feeds of supplemental information that come in files outside of claims files. Massachusetts collects such payments globally, where payers are asked to report the extent to which they are using alternative payment methods. This includes flexibility for payers to use their own definitions, but results in a lack of substantial granularity. Maryland spent approximately 18-months where they interviewed carriers in the market to determine how they track supplemental payments and what can be reported. Most alternate payment arrangements end up completely separate from the claims process. Accepting them on such supplemental files was most preferred by payers. Trying to tag payments on individual claim files was nearly impossible.

Topic – Consumer Focus Groups on Price Transparency

Q - Slide #61 provides information on the target audience for the consumer focus groups. One of the criteria looked for was individuals with high deductible health plans. In the context of that, did the study look specifically at if those individuals had Health Savings Accounts (HSAs) or Health Reimbursement Arrangements (HRAs)?

A – Yes. That information was captured in the study eligibility screening documents, so the researchers could consider it as a variable in analyzing the responses.

Q – Did you consider partnering with a Web M.D. type of vendor to steer consumers toward the information on Health Data NY?

A – No.

Topic – Relationship Between APD and OHIP

Q – From Health Plan

What is the relationship between APD and OHIP? OHIP measures certain claims data submissions and lately has been aggressive in enforcing their standards. Does the APD communicate with OHIP on the progress of APD data intake initiatives, letting them know of technical challenges and what to realistically expect during the development/transition?

A – APD staff work closely with OHIP on a daily basis regarding data submission, and we want to know of any potential issues so they can be promptly and effectively addressed. Any payer with specific issues should be encouraged to contact the APD staff directly to discuss.