



# Claims and Clinical Data Integration: Claim-based Databases, including All Payer Claims Databases

Federal roles and opportunities to advance, improve claim-based databases and APCD developments in states

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- Multiple Ways to Accomplish
  - Leveraging current APCDs
  - Leveraging Medicare Qualified Entities
  - Leveraging other State /Regional efforts
  - Forming Something New: APCD and/or Other



- <u>Purpose</u>: public reporting, rate setting, "total cost of care"
- <u>Data Inclusion</u>: medical, pharmacy and dental claims data with eligibility and provider files from private and public payers and non-claims clinical
- <u>Accountability, Oversight/Data Rules of Engagement</u>: role of the state and/or multi-payers
- <u>Policy/Legal</u>: mandatory/voluntary by payers
- <u>Business Operations</u>:
  - De-identifiable/identifiable data into the database
  - De-identifiable/identifiable data upon release from the database



#### **Considerations No Matter Which Option Selected**

- <u>Security Mechanisms and Consent Management</u>: dependent on parameters
- <u>Data Source and Quality</u>: mapping
- <u>Data Extraction, Transport/Transformation and Aggregation</u>: role of HIE
- <u>Reporting, Consumer and Provider Tools</u>:
  - Dependent on data use/purpose and dissemination strategy
- Financing:
  - Role of Medicaid, state non-Medicaid, non-state



### Health IT and APM Framework (adapted from Health Care Payment Learning and Action Network APM Framework)

	Category 1 Fee for Service - No Link to Quality & Value	Category 2 Fee for Service - Link to Quality & Value		Category 3 APMs Built on Fee-for-Service Architecture		Category 4 Population-Based Payment		
		A Foundational Payments for Infrastructure & Operations	<ul> <li>B (Pay for Reporting)</li> <li>C (Rewards for Performance)</li> <li>D (Rewards and Penalties for Performance)</li> </ul>	A APMs with Upside Gainsharing	B APMs with Upside Gainsharing/Downside Risk	A Condition-Specific Population-Based Payment	B Comprehensive Population-Based Payment	
Current Health IT Infrastructure	Organizational EHR	:		Organizational EHR with interoperable summary clinical data				
		Event notifications (i.e., ADT: fax; spreadsheet; Direct)						
		Query for clinical data from another organization or system           Separate care coordination system with manual data entry to create care plans						
			EHR CQMs		Near real-time, provider-based e	CQMs	•	
			Manual chart review & claims bas	ed CQMs	Risk scores from payers to partici	ipants based on claims data		
			Manual submission of	Basic provider directory for patient attribution (i.e., spreadsheet)				
		CQMs to payers		Limited historical claims data sent from payer to provider/organization				
				Linking of organizations' patient	data to limited payer data			
				Organization level data warehouse for claims & clinical data				
				ETL methods for pulling clinical data from EHRs				
					Preadjudicated claims from the or	rganizations in the APM		
					General benefit & eligibility informa	tion available to establish referral netw	orks along with estimated cost da	
			*					
Ideal Health IT nfrastructure	Organizational EHR with inter	operable summary clinical data		Organizational EHR with all clin	ical data interoperable		EHR & Community-based/ social service systems with all clinical data interoperabl	
intrastructure		Closed referral loop	:		:		:	
		Shared care plan integrated with	EHR and available to entire clinical	care team, patient, & their caregive	rs	Shared care plan integrated with any system & available to entire care team (clinical, community-based/social services, patient, & caregivers)		
		Event notifications integrated into workflow			<u>!</u>	Event, care gap, and change in risk score notifications integrated into workflow		
			Limited claims data sent from payer to provider/ organization	Real-time risk scores from claim	: ns & clinical data	Real-time, disease specific risk scores from claims & clinical data	Real-time risk scores from claims, clinical, & socio-economic data	
Key EHR System Care Coordination/Management Quality Measurement			Organization data ware- house to combine clinical & claims data	Aggregate multi-payer (commercial, Medicaid, & Medicare) adjudicated claims data & multi-organization clinical data that's available to all participants in APMs				
			Linking of organizations' patient data to limited data set from payers	Interoperable provider directory – hierarchical & relational				
				100% accurate linking of claims and clinical data from multiple organizations				
Data Aggregatio	on & Attribution		Near real-time, provider- based eCQMs	Real-time patient-centric eCQMs contracts	: s calculated across systems or	Real-time patient-centric eCQMs	: calculated across a set populatio :	
Risk Scoring			Majority of CQMs are	Near-real-time benefit eligibility information & evidence-based CDS available at time of order				
			Majority of CQMs are eCQMs & can be reported to multiple payers	Near-real-time benefit eligibility i	nformation & evidence-based CDS a	available at time of order Provider value score available a	t time of order – cost	

#### Findings from Environmental Scan

- A small number of multi-stakeholder HIOs are working with payers and health systems to provide the health IT capabilities described in the Health IT Framework.
- The lack of interoperability and lack of standardized claims/encounter and clinical data is an impediment to data synthesis.
- There are multiple approaches being taken to data aggregation across APMs.
- Organizations are treating identified data as a proprietary asset.

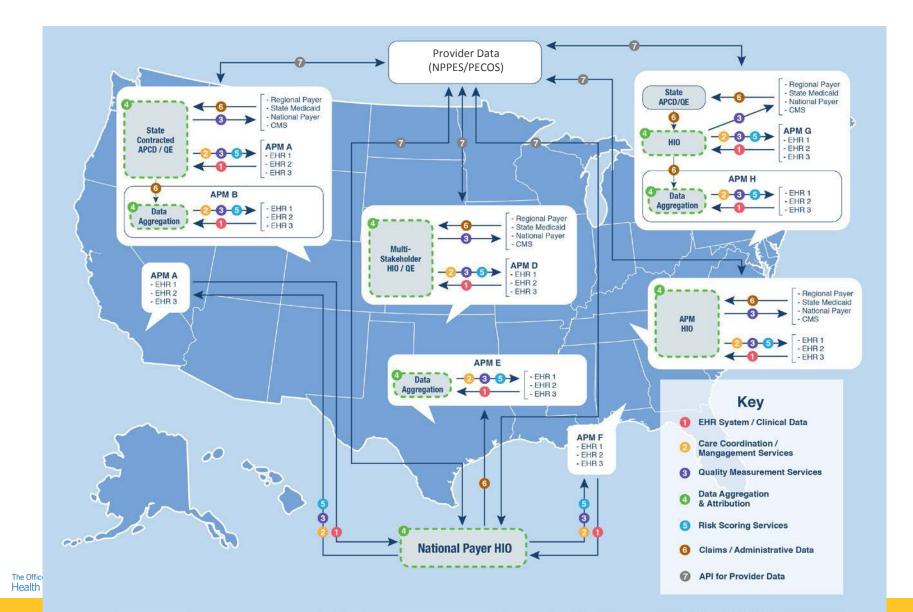


### In near term, existing multi-payer claims and clinical data aggregators need to be leveraged

- All Payer Claims Database (APCD)
- Multi-Stakeholder HIO
- Private HIO
- Regional Health Collaborative
- Qualified Entity (QE)
- Qualified Clinical Data Registry (QCDR)



#### **Regional and Marketplace Based Data Aggregation**



## Considerations re: the Federal Role in enabling multi-source data aggregation

- Multi-payer claims and clinical data aggregation will be necessary as more providers shift to population based payments in APMs.
- There needs to be a scalable more deliberate approach to fostering the development of this infrastructure nationwide to support the HHS and HCP-LAN goals for payment reform.
  - One to one sharing between payers and providers is not scalable.
- Federal and state government have policy levers that could facilitate payer and provider participation in qualified data aggregators

