Minnesota All Payer Claims Database Extract 23 Overview

Introduction

The Minnesota All Payer Claims Database (MN APCD) is a state repository of de-identified health care claims data that is derived from billing records sent by medical providers to insurance companies, plan administrators, and public payers. These data offer a unique opportunity for Minnesota to learn more about the health care services and prescription drug products provided across the state, their costs, and their impacts on health outcomes.

The MN APCD emerged from the 2008 State Legislative session as part of a forward-thinking package of health care reforms. More recently, the MN APCD's purpose and legislative mandate were amended to encompass a broader research and analytic agenda that could inform health care planning and public policy decisions.

This publication provides an overview of the MN APCD, including a history of the database, its contents and structure, and how the data are currently used.

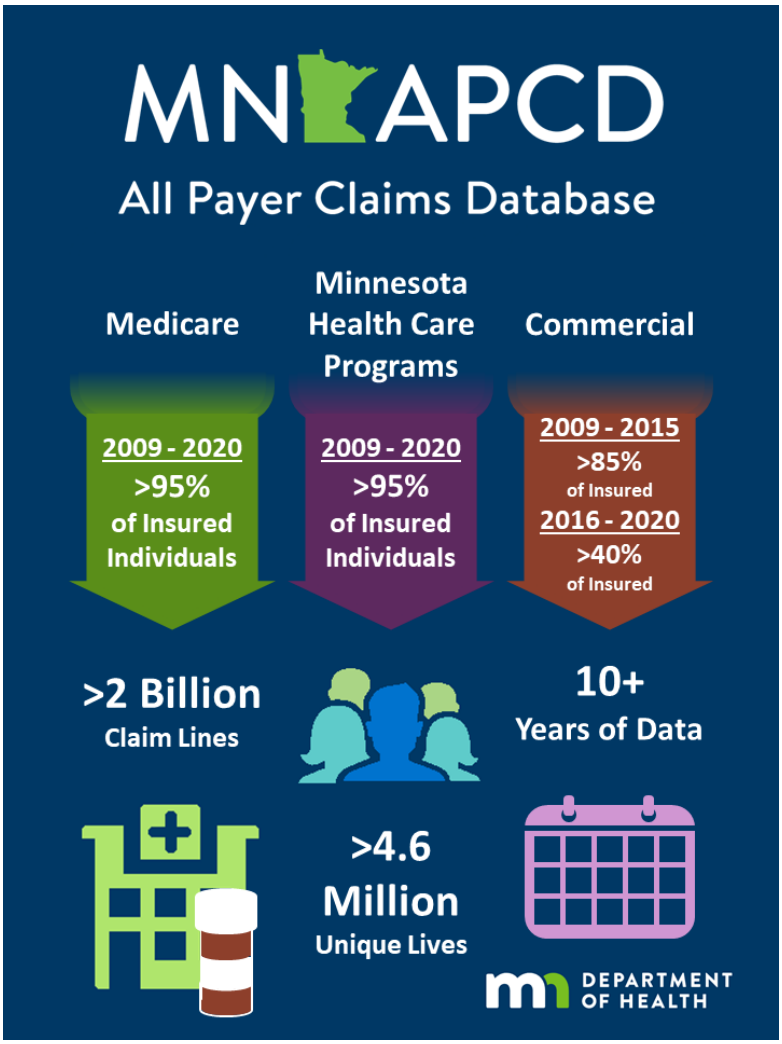
What are health care claims data?
Every time a person receives a medical service, the doctor, hospital, clinic, or lab (to name just a few) generates a claim or request for payment. The claim lists standardized codes for each service and where and when it was provided. Like an "Explanation of Benefits" sent to a member, the claim shows the submitted charges, the allowed amount, the payment to provider, and any patient deductibles and other cost-sharing. As is typically the case, the specific claim does not include payments outside the insurance and remittance process, such as incentives, withholds, or shared savings. The claim does not include test results, "signs and symptoms," or notes of conversations between a doctor and patient.

What is the Minnesota All Payer Claims Database?

The MN APCD systematically collects and integrates medical claims, pharmacy claims, and eligibility files from private and public payers. There are three distinct advantages of these data:

1. They represent the single most comprehensive view of health care in Minnesota.
2. They include health care claims submitted by nearly all private and public payers.
3. They cover the spectrum of care delivery, including inpatient hospitalizations, outpatient office visits, telehealth, and prescription drugs.

Protecting individual privacy in the MN APCD is of paramount importance. Before any information leaves data submitters' systems, members' names and dates of birth are converted into unrecognizable strings of letters and numbers that cannot be decoded or reversed. The MN APCD *does not* collect - in any form - Social Security Numbers, genetic information, telephone numbers, photographs, or notes from conversations between patients and caregivers.



The data also identify the place of service where the patient was seen, such as a hospital, a doctor's office, an urgent care clinic, or an ambulatory surgery center.

Data collection for the MN APCD is performed by a private non-profit contractor (currently Onpoint Health Data) selected through a competitive procurement process. The Minnesota Department of Health (MDH) provides oversight and management of the data collection effort. Statute currently authorizes only MDH and its contractors to access the data for a specified set of purposes.

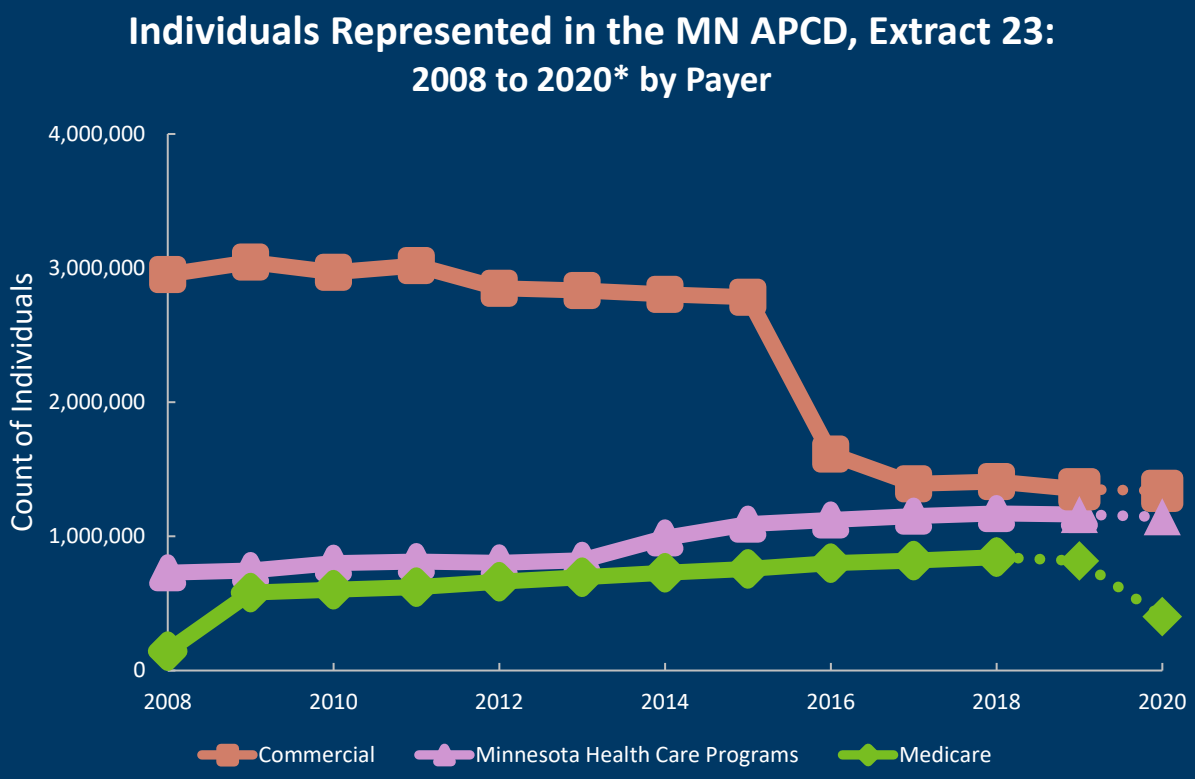
History of the MN APCD

Minnesota is one of eighteen states with APCDs that are currently collecting data.
Six additional states are in the early stages of data collection and nine states are considering APCD legislation.

Each state's APCD reflects the unique perspective, needs, and priorities of that state, ranging from concern about value in health care to interest in making thoughtful policy decisions. Minnesota was one of the first adopters of an APCD. Minnesota's APCD is truly an "All Payer" claims database because it incorporates data from Minnesota Health Care Programs and Medicare as well as from commercial payers – thus permitting a rich and systematic analysis of health care spending, utilization, and outcomes.

Legislative Authority

The MN APCD emerged as an essential component of the health care reform package enacted by a bi-partisan Minnesota State Legislature and signed by Governor Tim Pawlenty in 2008. The reform package made investments in public health, expanded access to insurance coverage, authorized the establishment of health care homes, and set the stage for payment reform and price and quality transparency. Among other things, the reforms sought to enhance transparency in the value of health care. The MN APCD was built to provide the data needed to develop the analyses relevant to health care reform.



*Medicaid is complete for all of 2020, commercial is complete through quarter 2 of 2020, and Medicare is complete for 2018 (Part D through 2018, FFS through 2019, and with partial MA data in 2020).

Data submission began in mid-2009 and included de- identified claims data for dates of service beginning on January 1, 2008. Since that time, the State made significant investments in building the data system and infrastructure. MDH has also established analytic expertise to support a wide range of data uses.

In 2014, the Legislature expanded MDH's authority to use the MN APCD to include several specific areas of inquiry, including:

- Evaluating performance of the Health Care Homes program
- Studying hospital readmission rates and trends, in collaboration with the Reducing Avoidable Readmissions Effectively (RARE) campaign
- Analyzing variations in health care costs, quality, utilization, and illness burden based on geographical areas or populations
- Studying trends in health care spending for specific chronic conditions and risk factors

Development of Public Use Files

The 2015 Minnesota Legislature directed MDH to produce publicly available MN APCD summary data. In developing MN APCD Public Use Files (PUFs), MDH consulted with an advisory workgroup and other potential users to determine the contents of the files and decide how to

ensure that any data released struck the appropriate balance between transparency and legislatively required protection of patient, provider, and payer identities.

More information on the development and contents of these files and how to obtain them can be found at the MN APCD Public Use Files webpage (www.health.state.mn.us/data/apcd/publicusefiles/index.html)

Data Sources, Scope, and Covered Populations and Services

State law (Minnesota Statute 62U.04) authorizes MDH to collect data from health plan companies and third party administrators[1] ("data submitters"), which pay medical providers for the services they provide to patients. Minnesota Administrative Rules determine which health plan companies must submit data to the MN APCD. Companies with less than $3 million in annual medical claims and/or $300,000 in annual pharmacy claims are exempt from data submission requirements of the MN APCD. Minnesota Administrative Rules (Chapter 4653) also provide data submitters with detailed instructions about how to organize the files and deadlines for submission.

Data submitters to the MN APCD include commercial health plan companies, third party administrators (including pharmacy benefit managers, or PBMs), Minnesota Health Care Programs, and Medicare. See box below for categories of medical and pharmaceutical claims that do not typically appear in the MN APCD.

Submitted data are compiled from medical bills sent by providers to payers to request payment. The bills are usually submitted electronically and include costs and payments for services provided, as well as codes that describe medical services such as hospital stays, outpatient clinics visits, MRIs, lab services, office visits, behavioral health services, therapies, and durable medical equipment. Similar information is sent to the patient on an Explanation of Benefits after the payer has determined the eligibility and final payment amounts. None of this information includes test results, treatment outcomes, or notes from private conversations between doctor and patient.

Currently, the MN APCD includes data for health care services delivered in 2008 through 2020 from more than 100 data submitters. The latest available full-year data is for 2019. It includes approximately:

- 4.11 million eligibility records per month
- 203 million medical claims
- 51 million prescription drug claims

Gobeille vs. Liberty Mutual Insurance Company

Completeness of the data submitted to the MN APCD by commercial plans and TPAs has been impacted by technical and legal challenges arising from the United States Supreme Court decision in *Gobeille vs.*

[1] A third party administrator, or "TPA," is often engaged by an employer or other entity to process insurance claims and/or other aspects of employee benefit plans. This often includes services such as paying claims, tracking member eligibility and deductibles, and providing record-keeping services. A health insurance company holds risk for medical services in that it accepts a fixed amount of money (a "premium") to provide all covered services. A self-insured organization hires a TPA for a set fee to pay providers' bills for covered services and manage members' eligibility and patient payment responsibilities. Other TPA services can include provider network design, employee wellness programs or disease management.

Liberty Mutual Insurance Company (2016), which limits states' authority to mandate data reporting for self-insured group plans governed by the Employee Retirement Income Security Act (ERISA). Fully insured insurance plans are not affected by the ruling. The decision does not prohibit the voluntary submission of ERISA-governed self-insured plan data to the MN APCD. As a result, beginning in early 2016 the volume of commercial claims and eligibility data submitted to the MN APCD decreased substantially, with early analyses indicating that data for roughly half of the commercially insured population is being withheld. For every year from 2009 to 2015, the MN APCD contained enrollment and claims for more than 80% of the total commercially insured population. In years following this submission decrease, the portion of the commercially insured population with data in the MN APCD has dropped to roughly 40%. This reduction in commercial claims data completeness will be an ongoing issue across all MN APCD extracts until further notice. MDH continues to work on assessing and documenting the full impact to MN APCD data.

Data Quality

An important area of MDH's efforts associated with the MN APCD concerns studying and documenting data quality, with a focus on data accuracy, consistency, and reliability. This is important work for two reasons. First, a complete understanding of data quality is key to continuously improving data over time, and this is paired with the development of new logic checks and data intake procedures. Second, when making PUFs available for independent research in the community, it is essential that researchers have a full understanding of data quality to guide the development of research questions, analysis plans, and appropriate interpretation of findings.

All submitted claims and enrollment data are subjected to rigorous quality checks, including confirmation of alignment with submission guidelines. No data are accepted until they have passed quality review and tests to confirm that no patient identifiers are included.

Once the data have been preliminarily accepted, MDH's data vendor conducts a secondary data quality review, assessing how the data compare with previously submitted values and accepted claim norms, confirming that conditions or procedures associated with members of a particular sex are consistent with expectations, and checking that data cell fill rate targets are met.

Additional information about the Minnesota APCD is available at the Minnesota APCD webpage (https://www.health.state.mn.us/data/apcd/index.html).