Center for Healthcare Transparency
Subgroup Meeting Highlights
(phone meetings in September and October)

Claims Data Subgroup

The group identified specific barriers to address for a robust 2020 Implementation Plan, including:

- Inability to get certain data, such as allowed amounts
- Data quality issues stemming from:
  - Incomplete fields
  - Lack of well-defined standards for data extraction
  - Inconsistency of interpretation/coding of fields even within a standard layout, lack of robust definitions
  - Vendors simply not getting the right data in the right fields (e.g. billing vs. rendering)
  - Multiple "standard" file layouts within a given market as well as across the country and even within a single carrier for reporting in a single market
- Difficulty getting needed longitudinal data and doing all desired look backs
- The complexity of accurately matching provider data across multiple data sources
- The work required to get accurate, time-based provider-practice maps
  - Challenge of representing complex provider/practice relationships
    - For example, many specialists work one day a week in different practices
- Timing challenges when data from one plan comes in late or must be adjusted
- Challenges of using vendor, multi-step discovery process when questions arise
- Complexity of implementing certain Appropriate Use measures as the clinical screening steps become more complex yet measure choices are limited to "over use" "under use" and "appropriate"
- Complexity of steps required to share PHI with different actors

Members also offered up specific tactics for potential inclusion in the 2020 Implementation Plan and/or resource library such as, for example:

- Experiences and learning from attempts at (more) standardized file layout
- NAHDO standard file layout process
- Robust field definitions
- Using medical record review to ensure accurate physician matching
- Use of third party auditors trained in pay-for-performance reporting
- Quality control processes for validating in-patient bed days
- Leveraging an up-to-date Provider Directory as a statewide resource for multiple uses
- Multiple potential use cases for claims data: assessing pricing variability, identifying high value specialists, provider quality reporting, comparing providers' long term costs across episodes of care, assessing Medicaid usage rates, etc.

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Topics for Further Discussion

- Creating standard file layout that would go beyond the bare minimum, lowest common denominator elements
- Master Patient Index/Patient Matching
- Risk adjustment for quality data
- Incorporating benefit design information
  - Minimum basic info?
  - Deductible levels?
  - Payer set flags?
- How to help providers who don't trust, understand or know how to use claims data (see also Subgroup 1)
- Strengths and weaknesses of EnClarity, a vendor that offers Provider Directory Services nationally (discussion continued off-line)