CONNECTICUT

All-Payer Claims Database Advisory Group Meeting

August 8, 2024

AGENDA

ALL-PAYER CLAIMS DATABASE ADVISORY GROUP – AUGUST 2024

Topic	Presenter(s)
Welcome & Call to Order	Olga Armah, Chair
Public Comment	Members of Public
Minutes Approval: May 9, 2024	Chair & Council Members
APCD Projects – Status Updates	Olga Armah, Chair
Health IT Advisory Council Update	Sumit Sajnani, HITO
Presentations by OnPoint Health Data: Non-Claims Data & Public Use File	OnPoint Health Data Representatives
APCD Updates: Data Available	Olga Armah, Chair
APCD Data Release Committee Report	Dr. Patricia Checko, DRC Chair
Adjournment	Olga Armah, Chair

Public Comment

(2 minutes per commenter)

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Minutes Approval: May 9, 2024

APCD Projects – Status Update

Olga Armah, OHS

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APCD PROJECTS – STATUS UPDATE

Projects in Flight

- APCD Data Quality & Completeness Enhancements
- APCD Snapshot
- Statewide Facilities Plan
- Rand 5.0
- CT Healthcare Affordability Index
- Studies:
  - Behavioral Health Parity
  - Hospital Community Benefit
  - OnPoint Collective Impact Behavioral Health Dashboard

APCD Data Quality & Completeness Enhancements

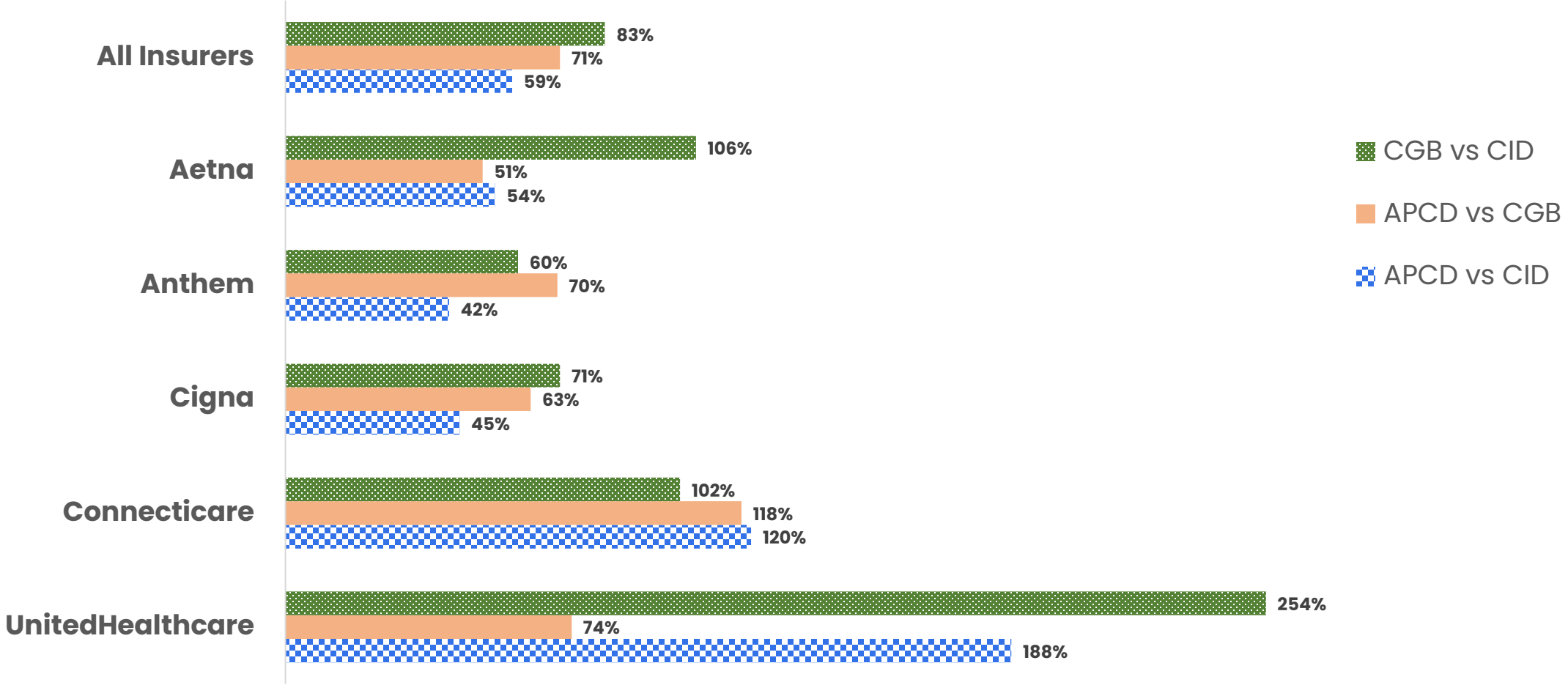
Data Completeness Background

- Objective- assess APCD's robustness in capturing commercial population by comparing to other data sources
  - Connecticut Department of Insurance (CID): 2023 Consumer Report Card for 2022 (and 2021)
  - 2021 and 2022 Cost Growth Benchmark Payer Data

- Main metric: Covered Members/Member Months in CY 2022 and 2021

APCD Covers About 60% of Commercial Population (2022)

All Coverage Types by Payer by Data Sources, CY 2022



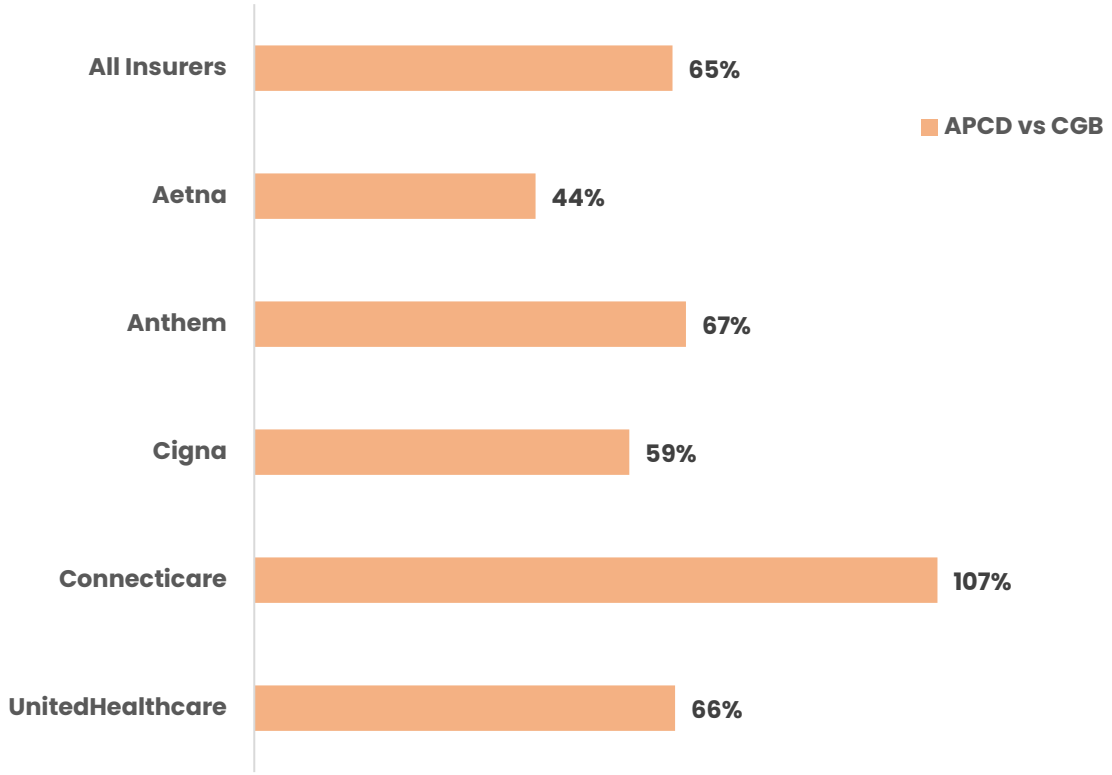
CID – Department of Insurance

CGB – Cost Growth Benchmark

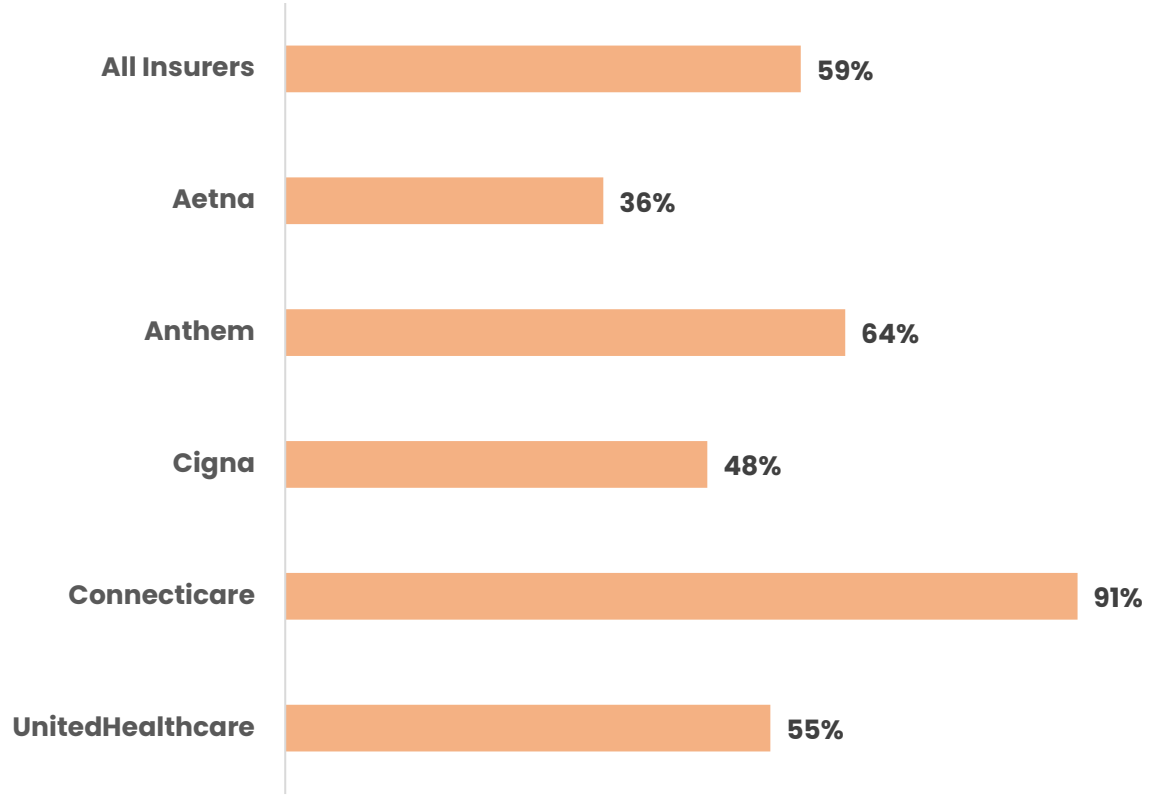
APCD – All Payer Claims Data

Member-Months: APCD Covers ~ 60% of CGB (2021 -2022)

All Coverage Types: Comparing Commercial Group Population by Data Source, CY 2022 (Member-Months)



All Coverage Types: Comparing Commercial Group Population by Data Source, CY 2021 (Member-Months)

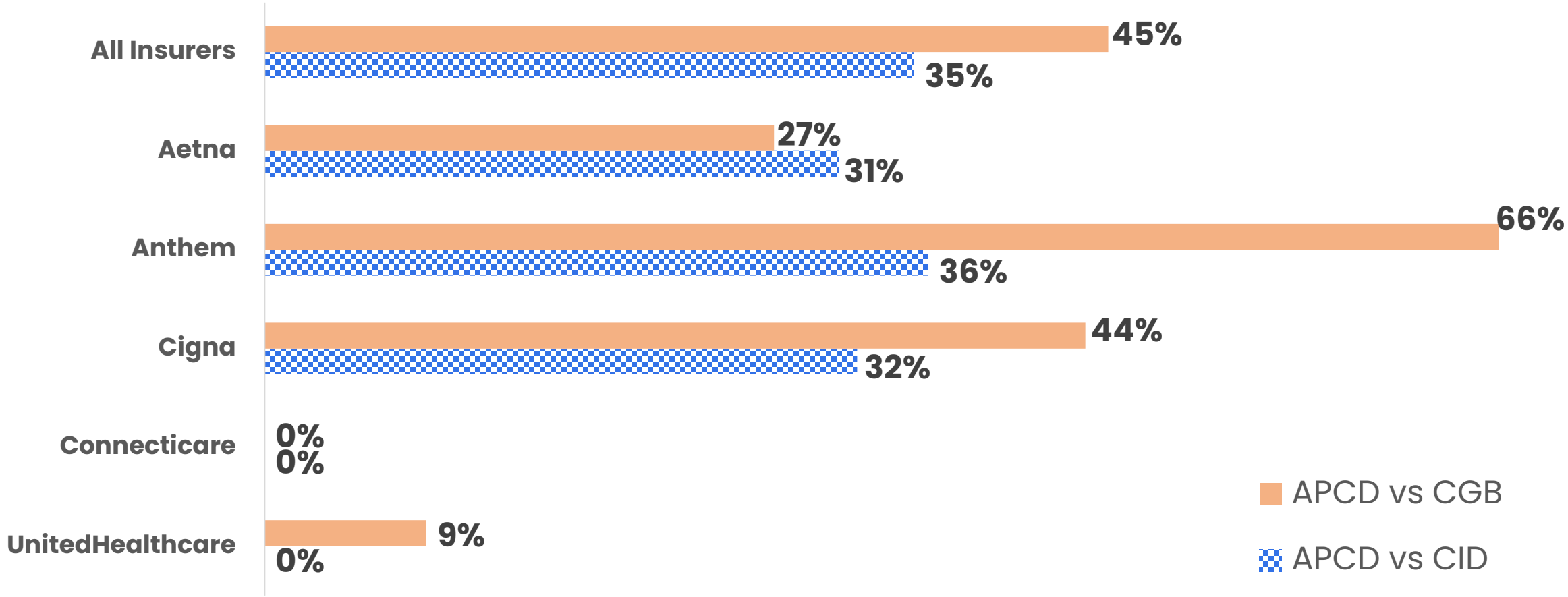


CGB – Cost Growth Benchmark

APCD – All Payer Claims Data

APCD Self-Insured Coverage is over a Third of CID's (2022)

Self-Insured Population Coverage by Data Source, CY 2022



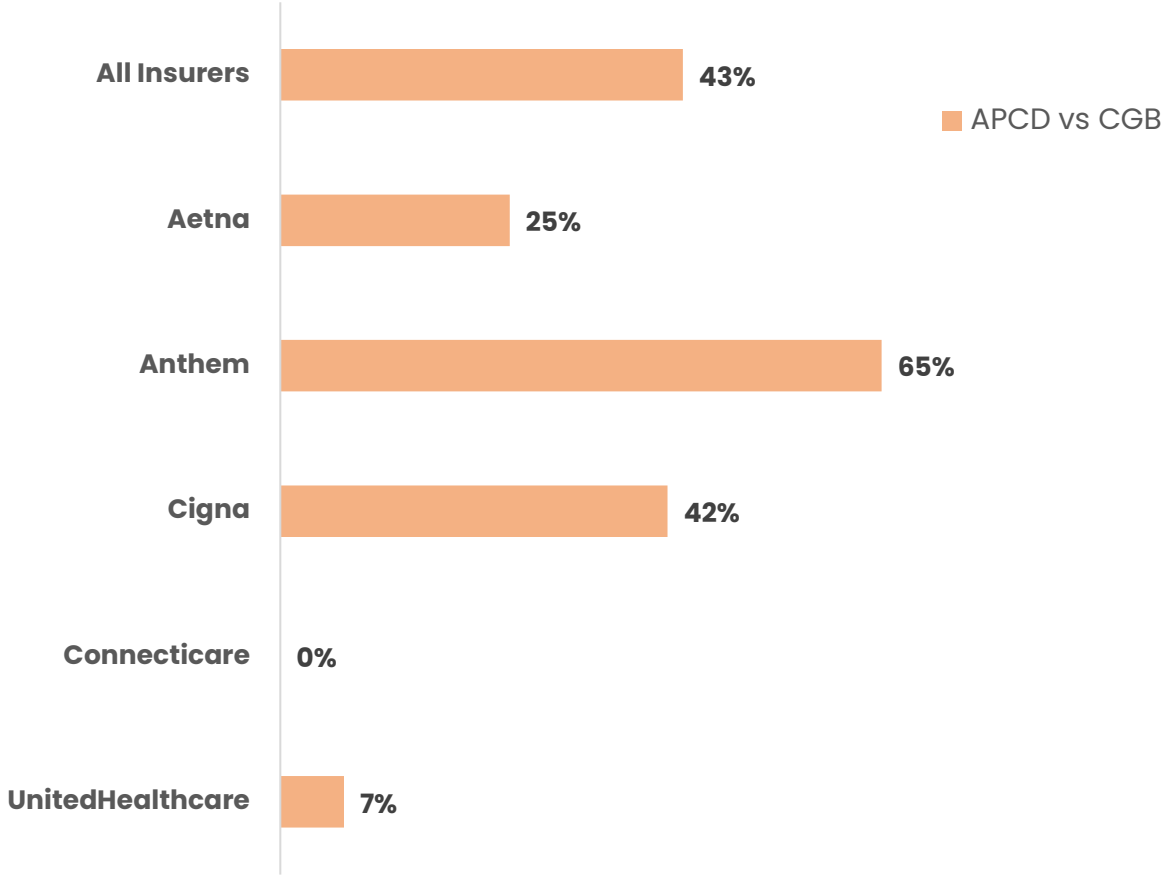
CID – Department of Insurance

CGB – Cost Growth Benchmark

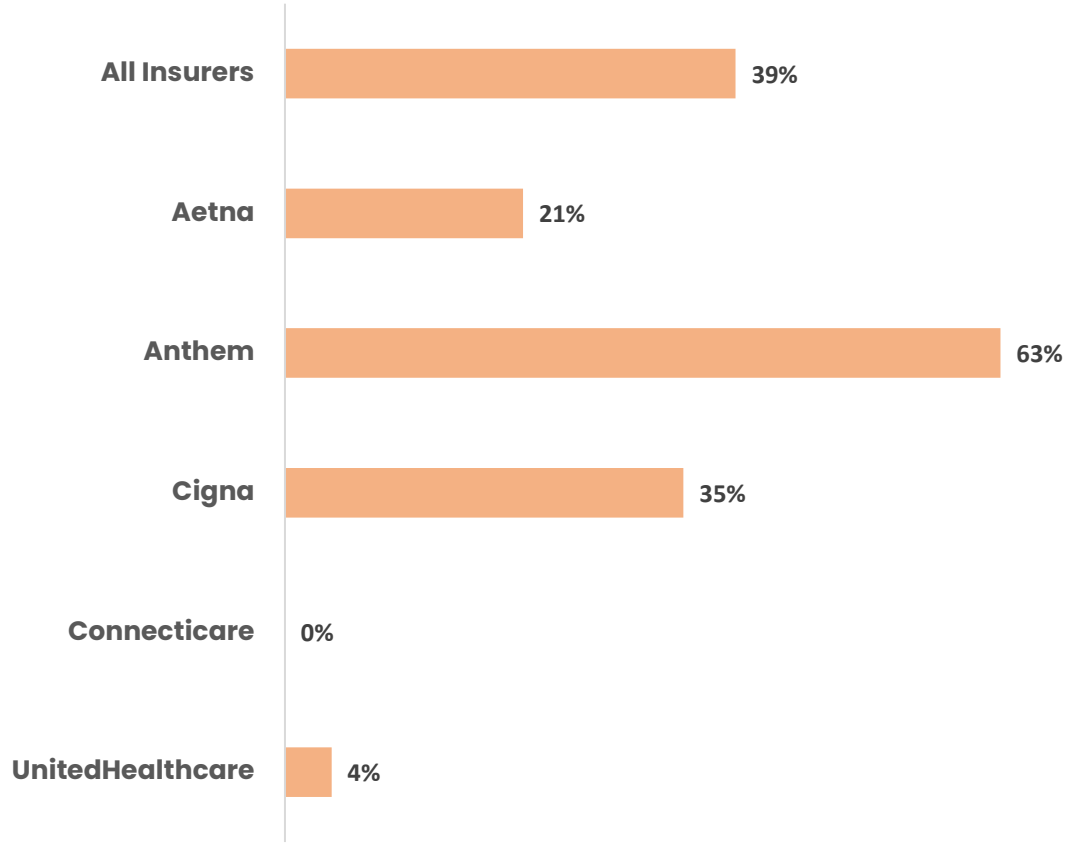
APCD – All Payer Claims Data

Member-Months: APCD's Self-Insured Coverage almost Half of CGB Coverage (2021 - 2022)

Self-Insured Population Coverage by Data Source, CY 2022 (Member-Months)



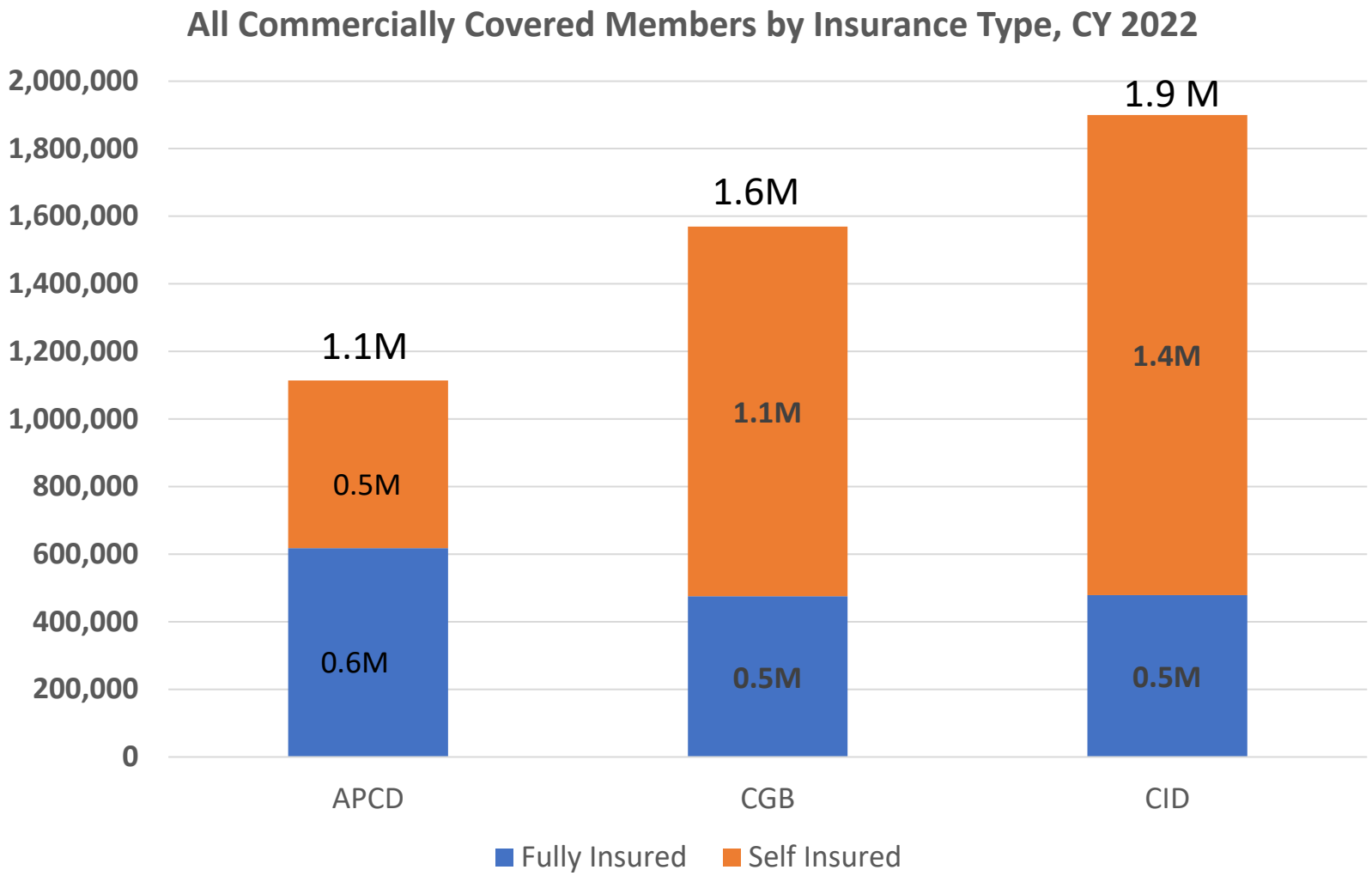
Self-Insured Population Coverage by Data Source, CY 2021 (Member-Months)



CGB – Cost Growth Benchmark

APCD – All Payer Claims Data

Full Commercial Population: Fully Insured vs Self-Insured

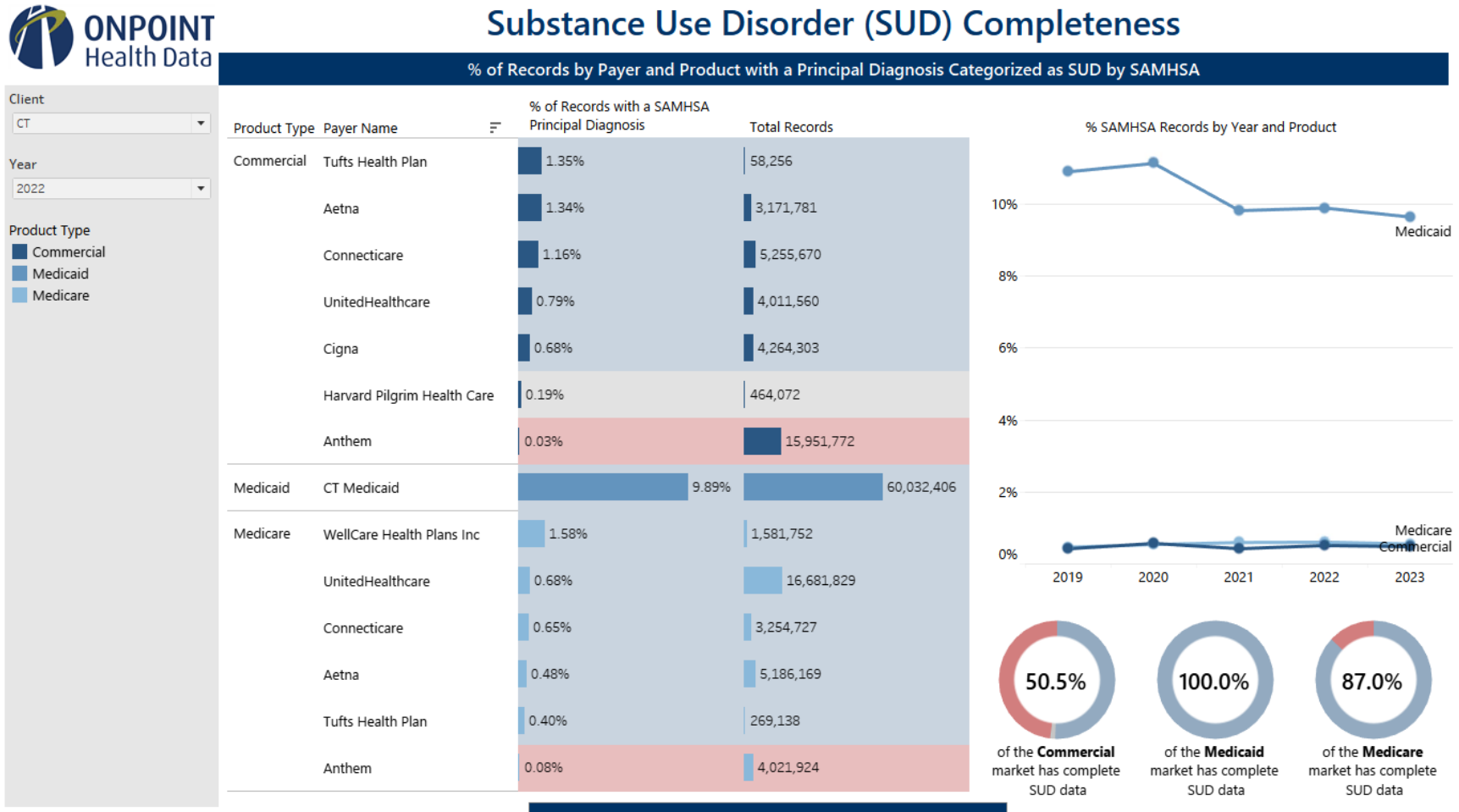


CID – Department of Insurance

CGB – Cost Growth Benchmark

APCD – All Payer Claims Data

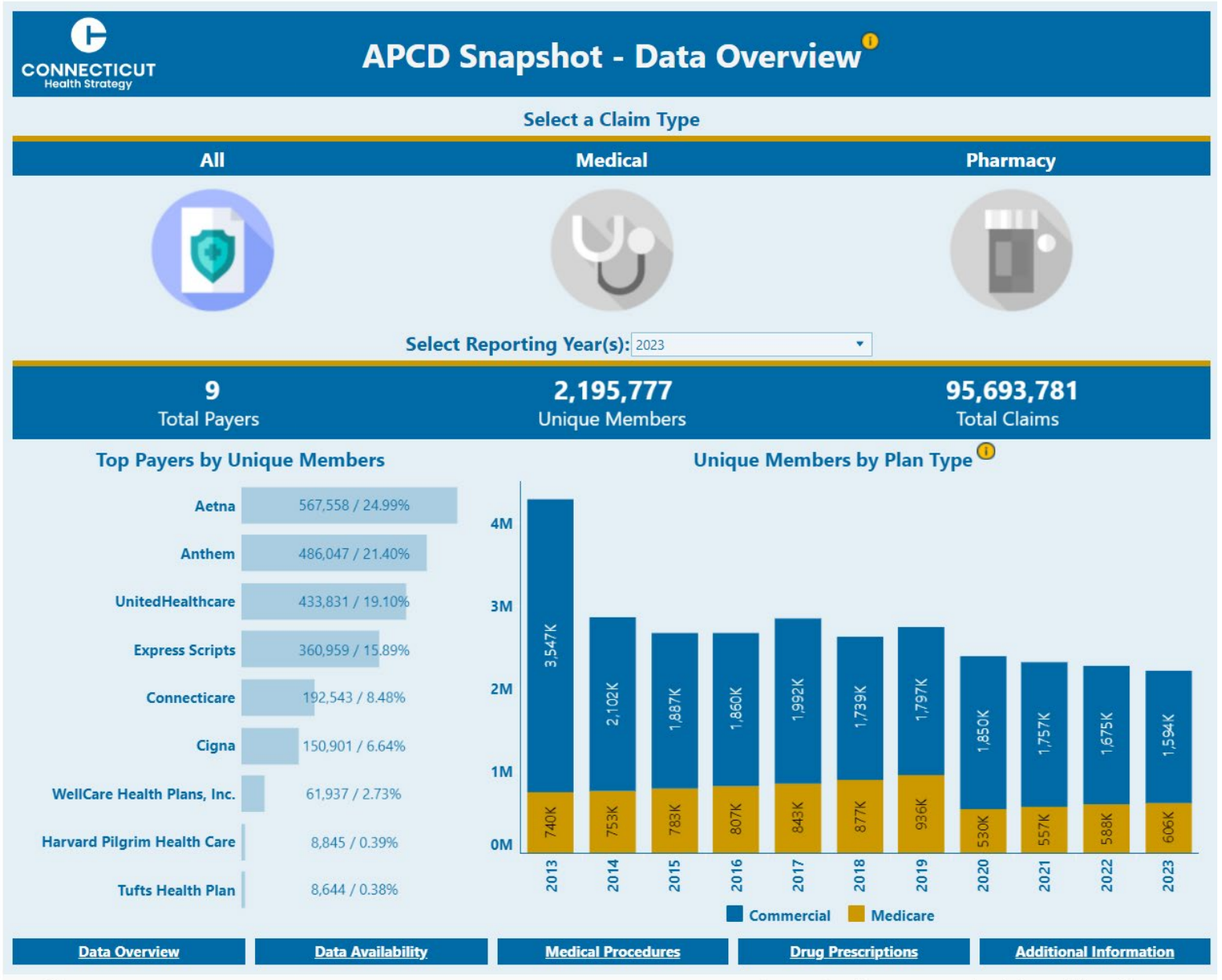
Substance Use Disorder Data Completeness



	Payer Type		
SUD Data Availability Key	**Commercial**	**Medicaid**	**Medicare**
SUD data is available	≥0.3%	≥2.5%	≥0.15%
SUD data may contain gaps	>0.1% -- <0.3%	>1.0% -- <2.5%	>0.1% -- <0.15%
SUD data is not available	≤0.1%	≤1.0%	≤0.1%

Units: Percent of total medical claim service lines reporting an principal diagnosis of SUD as defined by SAMHSA

APCD Snapshot



Statewide Facility Plan

Table A10: MRI Population Utilization, by Primary Insurance Coverage and Region (Patient's location), 2021

	Rate per 1,000		
Connecticut Planning Region	**Medicaid**	**Medicare**	**Private**
Capitol Planning Region	97	230	111
Greater Bridgeport Planning Region	98	238	121
Lower Connecticut River Valley Planning Region	130	342	156
Naugatuck Valley Planning Region	118	262	124
Northeastern Connecticut Planning Region	134	319	151
Northwest Hills Planning Region	142	250	130
South Central Connecticut Planning Region	128	281	131
Southeastern Connecticut Planning Region	130	342	155
Western Connecticut Planning Region	109	322	145

Source: *Connecticut APCD Analyses*

Table A11: CT Population Utilization, by Primary Insurance Coverage and Region (Patient's location] 2021

	Rate per 1,000		
Connecticut Planning Region	**Medicaid**	**Medicare**	**Private**
Capitol Planning Region	289	780	173
Greater Bridgeport Planning Region	237	803	172
Lower Connecticut River Valley Planning Region	310	866	205
Naugatuck Valley Planning Region	294	825	201
Northeastern Connecticut Planning Region	337	930	231
Northwest Hills Planning Region	272	719	194
South Central Connecticut Planning Region	303	847	194
Southeastern Connecticut Planning Region	345	1,004	232
Western Connecticut Planning Region	229	773	169

Source: *Connecticut APCD Analyses*

Healthcare Cost Estimator

Connecticut Healthcare Cost Estimator Tool

The Connecticut healthcare cost estimator tool offers an easy-to-access cost estimate for commonly performed medical procedures and services, and commonly prescribed devices and drugs. The Tool aims to increase healthcare cost transparency for consumers.

How it works

This tool uses information you provide on your planned procedure and health insurance to estimate average total and out-of-pocket costs. Average costs are calculated using claims data for services that occurred between October 1, 2020 and September 30, 2022 from the state's all-payer claims database.

It provides commercial plan costs for several commonly performed procedures and commonly used medical devices and drugs.

Estimates are for employer-sponsored commercial insurance plans. Estimates for Medicare and Medicaid are not currently included.

Select a category

Durable Medical Equipment | Inpatient | Outpatient | Pharmaceutical

Disclaimer

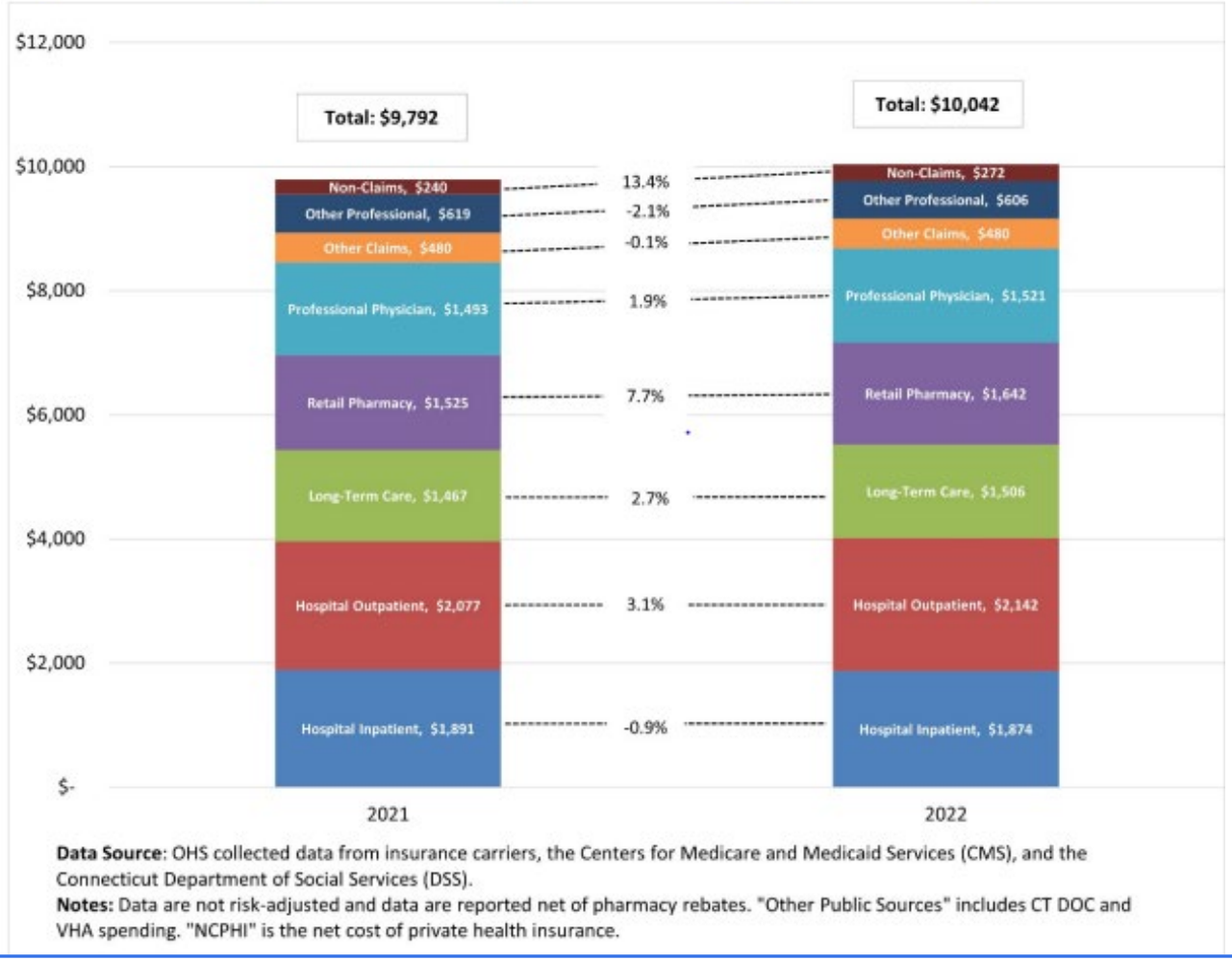
The information the tool provides is an estimate based on historical claims data and is not a price quote or guarantee of the final billed charges. Final billed charges may vary from this estimate for many reasons such as the patient's medical condition, unknown circumstances or complications, final diagnoses, and recommended treatment ordered by the provider. Fees for related services that may be rendered with selected procedures are not included in this estimate.
The Cost Estimator Tool was created by Mathematica®.

Home
Durable Medical Equipment
Inpatient
Outpatient
Pharmaceutical
Contact Us

Cost Growth Benchmark Hearing

APCD for Identifying Significant Contributors

Figure 6. Per Capita State TME by Service Category (2021-2022)



Data Source: OHS collected data from insurance carriers, the Centers for Medicare and Medicaid Services (CMS), and the Connecticut Department of Social Services (DSS).
Notes: Data are not risk-adjusted and data are reported net of pharmacy rebates. "Other Public Sources" includes CT DOC and VHA spending. "NCPHI" is the net cost of private health insurance.

Cost Growth Benchmark Hearing

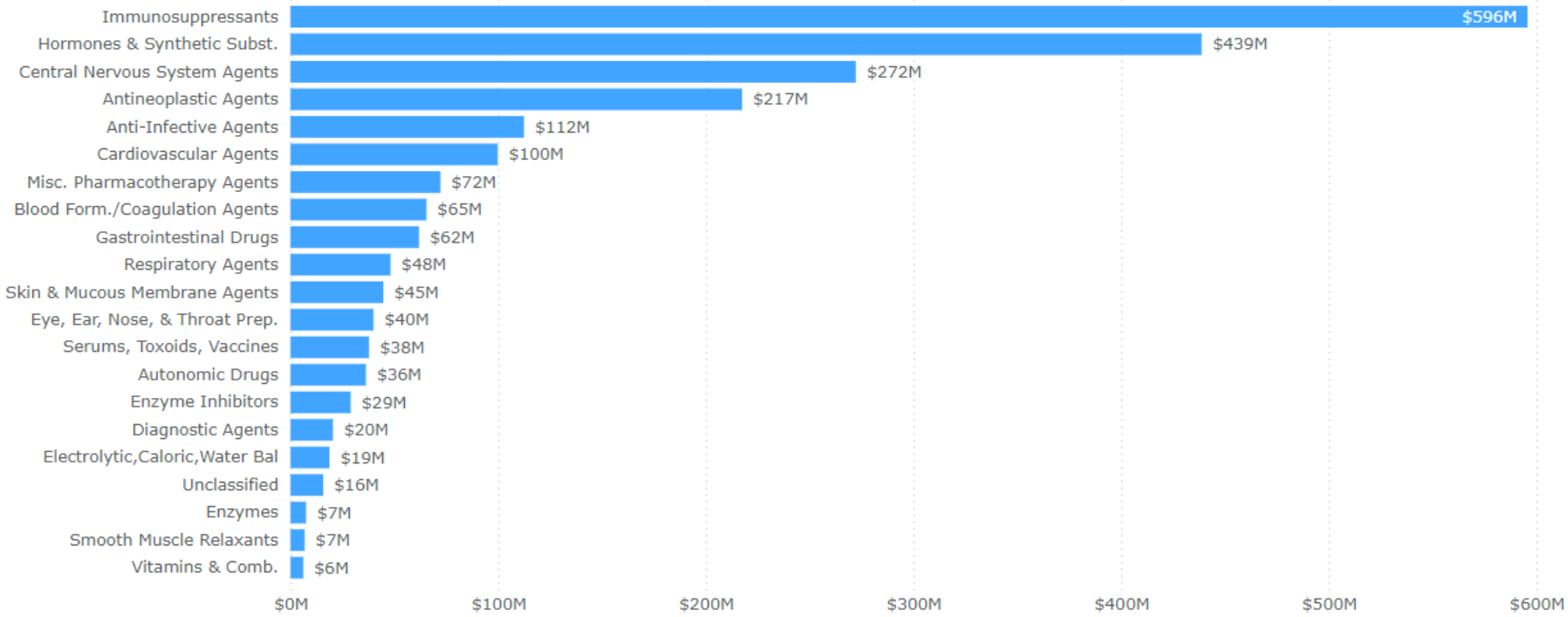
Significant Contributors

Glossary & Guide | Retail Pharmacy Overview | Spend by Drug Category | Drug Category Table | Drug Category Comparison | Highest Spending | Category Drilldown

CONNECTICUT Health Strategy

Retail Pharmacy Spending By Drug Category

Year	Market	Submarket	Generic/Brand	Age group	Gender
2022	COMMERCIAL	All	All	All	All



This table shows average per member per month spending (PMPM), payment per unit (PPU) and units per 1,000 members (UPK) by market, claim category and year for the most recent five years. Annual percent changes for each metric are also included. Optional filters include age group, gender, county, service category and submarket. Results can be sorted by hovering over a column header and clicking on the triangle. Pharmacy spending data do not account for manufacturer rebates. 2020 and 2021 trends are affected by the COVID-19 Public Health Emergency. Medicare FFS data are currently unavailable.

CT Healthcare Affordability Index (CHAI)

Select CHAI Model for Comparison ⓘ
(Multiple values)

Select Connecticut Town
Bridgeport

Select Healthcare Cost Factors ⓘ

Health Insurance Type	Health Risk Score	Adult Age Range
Individual Marketplace	Medium	35-49

Select Family Composition

Adults	Infants	Preschoolers	Schoolagers	Teenagers
2	0	1	1	0

Monthly Cost of Basic Needs in Bridgeport

Assumes Individual Marketplace Health Insurance for an 35-49 householder with a Medium Health Risk Score

	Original CHAI	ARPA (PTC Only) + 30.5% EITC	Cost Growth Benchmark
Housing	$1,293	$1,293	$1,293
Child Care	$2,289	$2,289	$2,289
Food	$953	$953	$953
Health Care	$2,469	$2,469	$2,340
Transportation	$140	$140	$140
Miscellaneous	$533	$533	$533
Taxes	$2,124	$1,607	$1,592
Premium Tax Credit (-)	$0	($1,193)	($1,111)
Earned Income Tax Credit (-)	$0	$0	$0
Child Tax Credit (-)	($333)	($333)	($333)
Child Care Tax Credit (-)	($100)	($100)	($100)
Income Needed to Meet Basic Needs			
Hourly Wage	$26.61	$21.75	$21.58
Monthly Income	$9,367	$7,657	$7,596
Annual Income	$112,401	$91,885	$91,149

Source: The cost of basic needs are based on the Self-Sufficiency Standard for Connecticut calculated by the University of Washington Center for Women's Welfare. The Connecticut Healthcare Affordability Index (CHAI) substitutes the original Self-Sufficiency Standard healthcare costs with detailed costs to account for factors that impact affordability including differences in (1) type of insurance coverage, (2) age-related premiums, and (3) out-of-pocket costs by health risk score of householder (low indicates good health; medium signifies chronic diseases that are controlled; high indicates chronic diseases that are uncontrolled or have related complications)

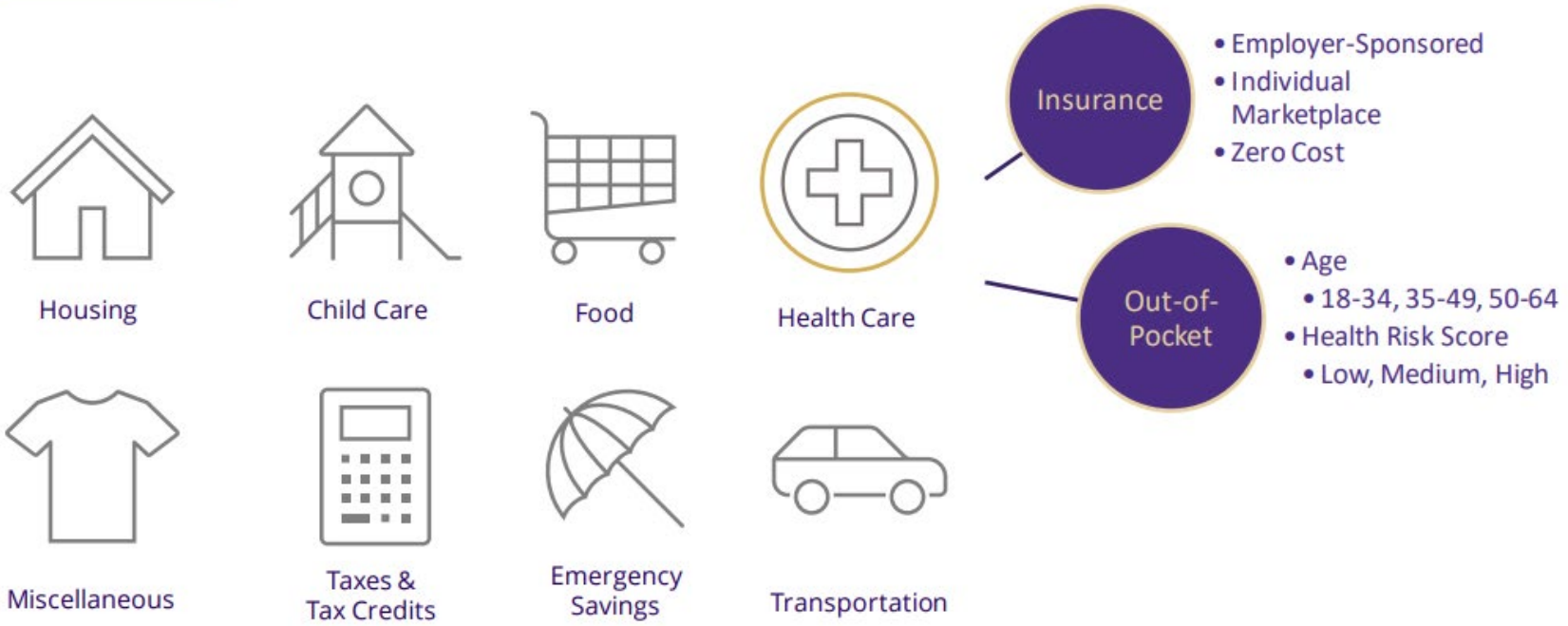
CT Healthcare Affordability Index (CHAI)

Understanding Healthcare Affordability

> More than just paying for insurance, it's about securing healthcare without sacrificing other basic needs like housing, food, transportation, and childcare.

CT Healthcare Affordability Index (CHAI)

Connecticut Healthcare Affordability Index (CHAI)



CT Healthcare Affordability Index (CHAI)

How many can't afford their basic needs in Connecticut?

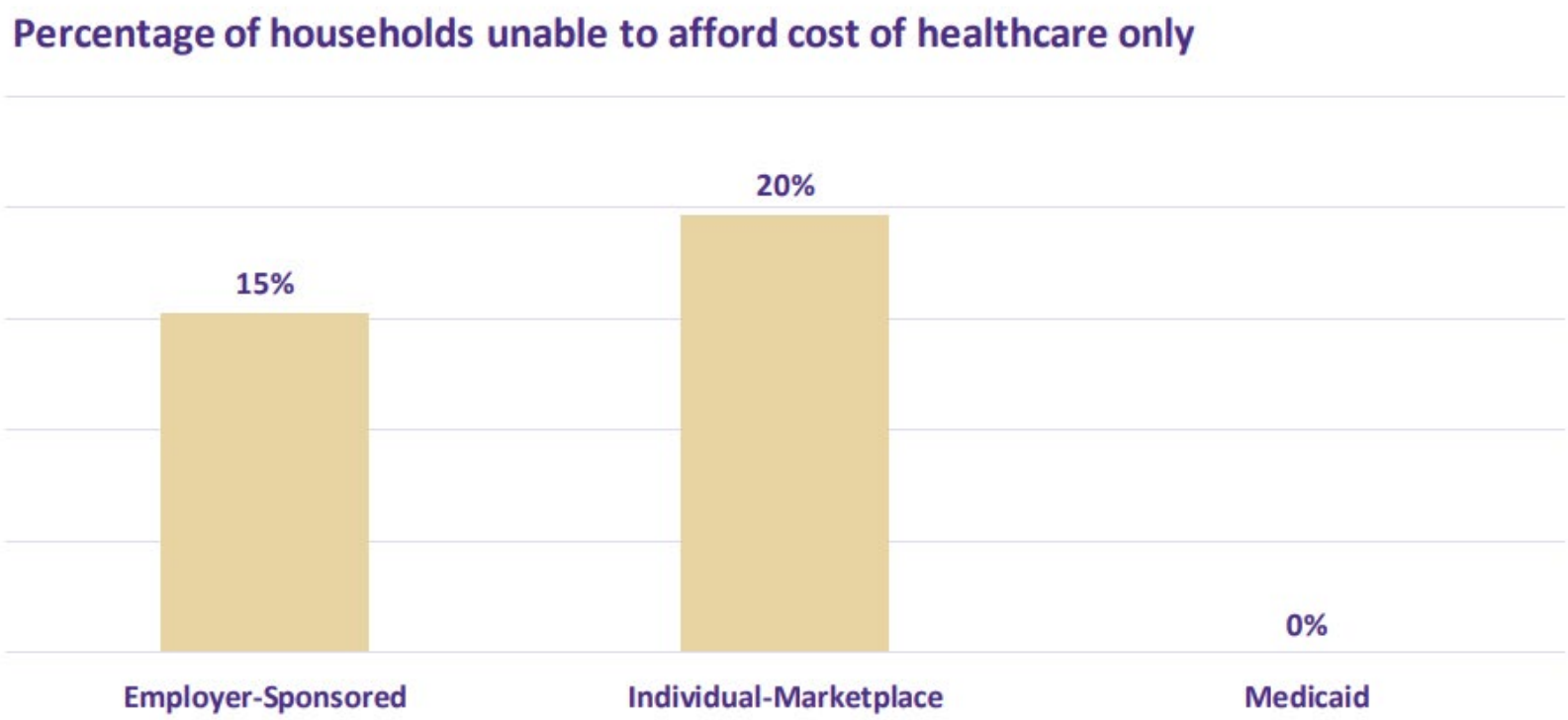
300,000 Households

650,000 Individuals

260,000 Children

CT Healthcare Affordability Index (CHAI)

13% of households couldn't afford their healthcare costs in 2022



RAND 5.0 – Employer Hospital Prices Transparency Project

- Includes claims data, provider identifiers and allowed amounts, for enrollees in employer-sponsored health plans from three types of data sources:
- Self-insured employers;
- State-based all-payer claims databases: Arkansas, Colorado, **Connecticut**, Delaware, Maine, Minnesota, New Hampshire, Oregon, Rhode Island, Utah, Vermont, and Washington
- health plans that chose to participate.
- Together, those data sources include claims data for hospital services provided by more than 4,000 hospitals in 49 states and Washington, D.C.
- Claims data for 2020 – 2022.
- Prices are calculated based on allowed amounts, including amounts paid by the health plan and the patient.
- Relative prices represent the allowed amount paid by the private plan as a percentage of what Medicare would have paid to the same hospital for the same services.
- Standardized prices represent the allowed amount paid by the private health plan per service, standardized using Medicare's case mix grouping and relative weights.
- Source: https://www.rand.org/pubs/research_reports/RRA1144-2.html

Connecticut RAND 3.0, 4.0, 5.0 Results

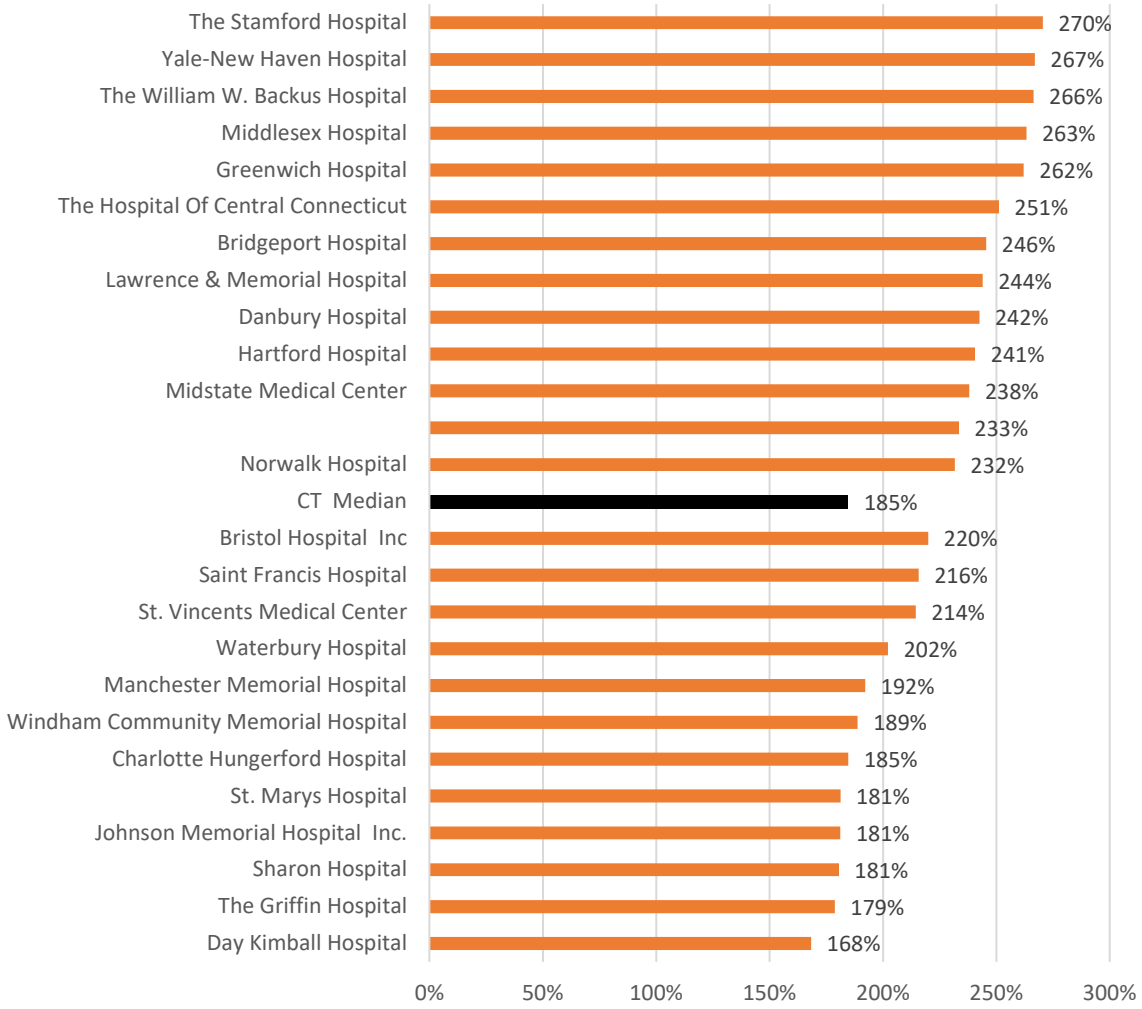
State-Level Average Prices Paid by Private Employer-Sponsored Health Plans Relative to Medicare, 2018 - 2022

						Connecticut			
Study	Data on Hospitals, States & DC	Years of Data	Min	Max	CT Rank	Relative price	Relative price, IP	Relative price, OP	Relative price, Professional
Rand 3.0	3,000 & 46 states	2016 - 2018	186%	351%	7	215%	203%	230%	178%
Rand 4.0	4,000 & 49 States	2018- 2020	147%	322%	17	219%	206%	239%	171%
Rand 5.0	4,000 & 49 States	2020 - 2022	164%	345%	28	258%	250%	265%	202%
Growth over time			**-12%**	**-2%**		**20%**	**23%**	**15%**	**13%**

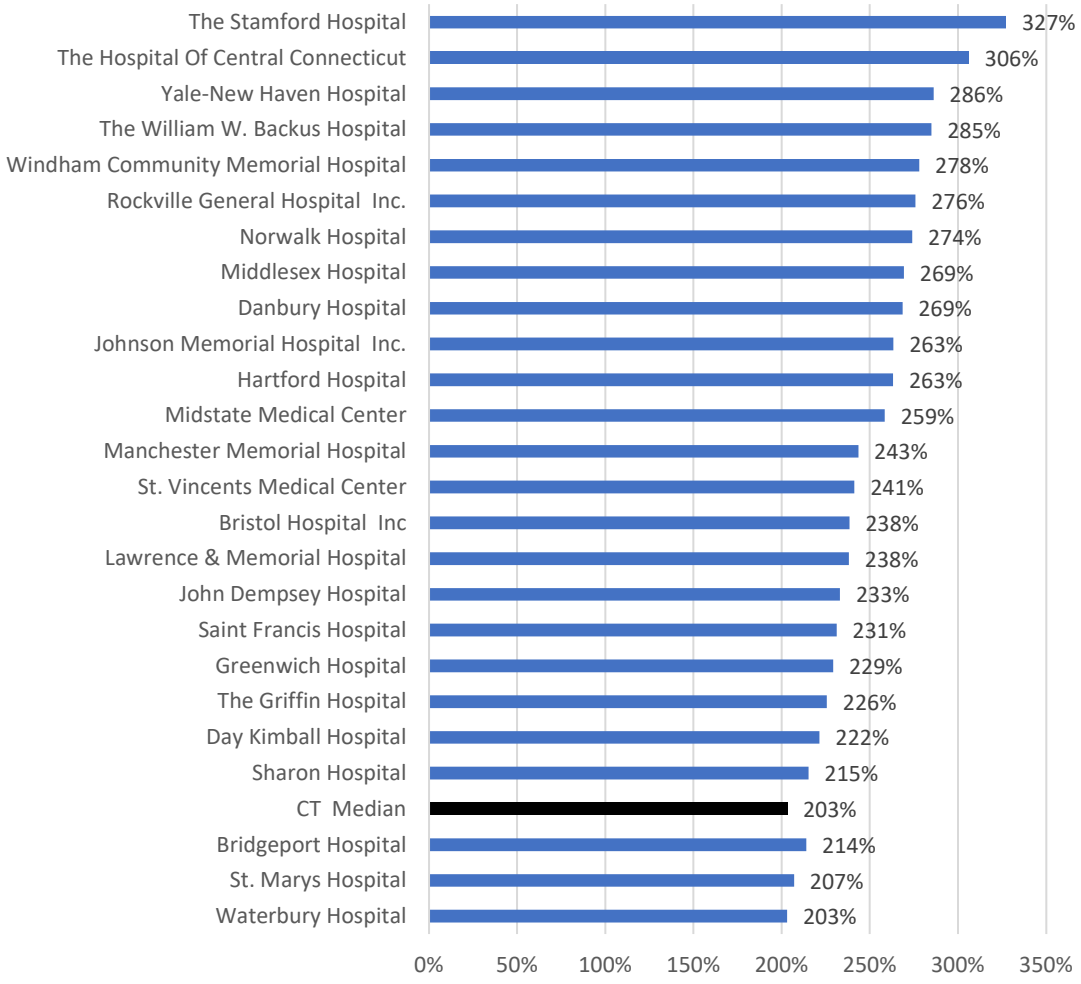
Source: Rand studies 3.0, 4.0, 5.0. utilizing claims data, provider identifiers and allowed amounts, for enrollees in employer-sponsored health plans from three types of data sources: self-insured employers, state-based all-payer claims databases and health plans that chose to participate in studies.

RAND 5.0 Results: CT Hospitals

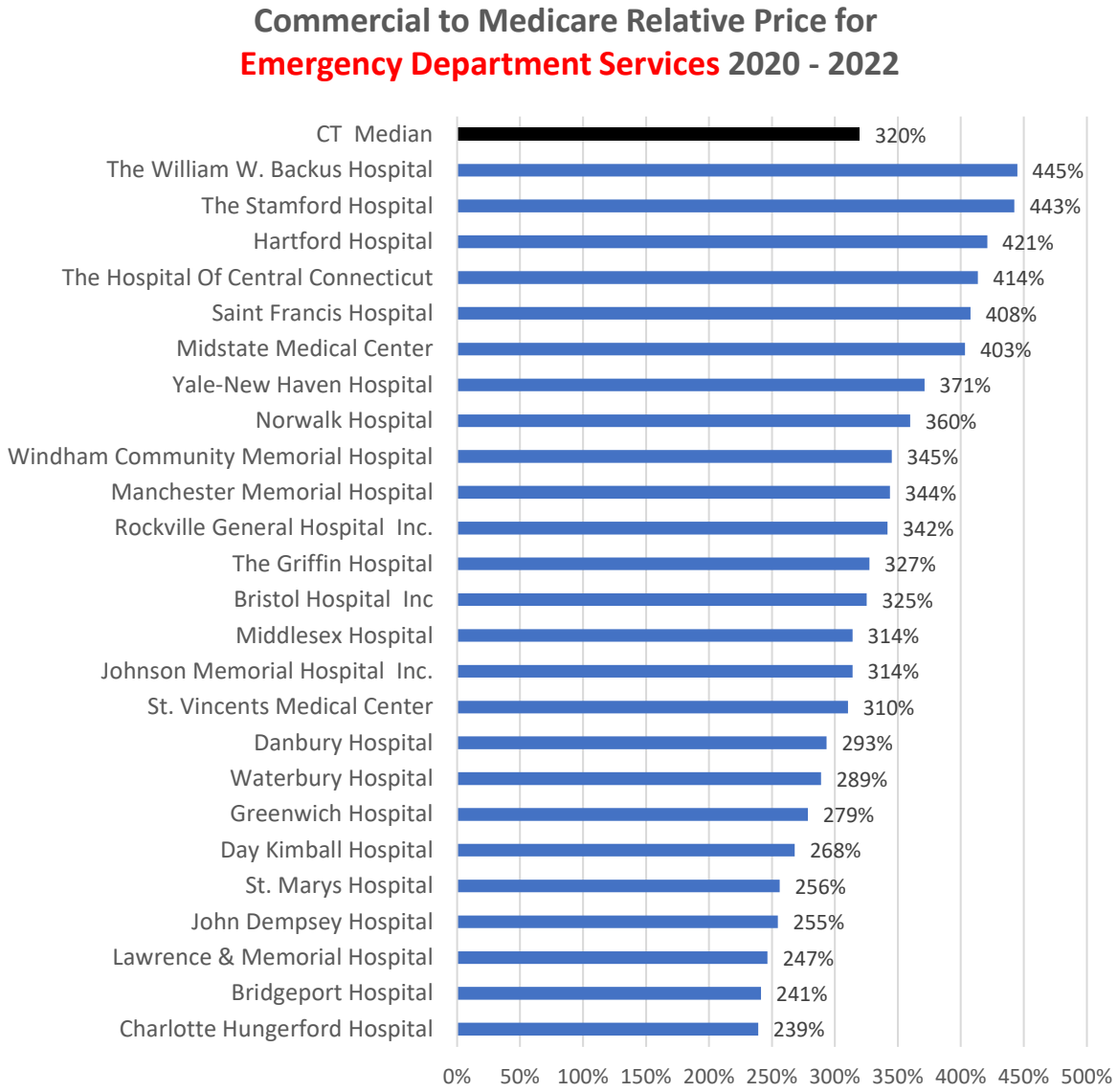
Commercial to Medicare Relative Price for Inpatient Services 2020 - 2022



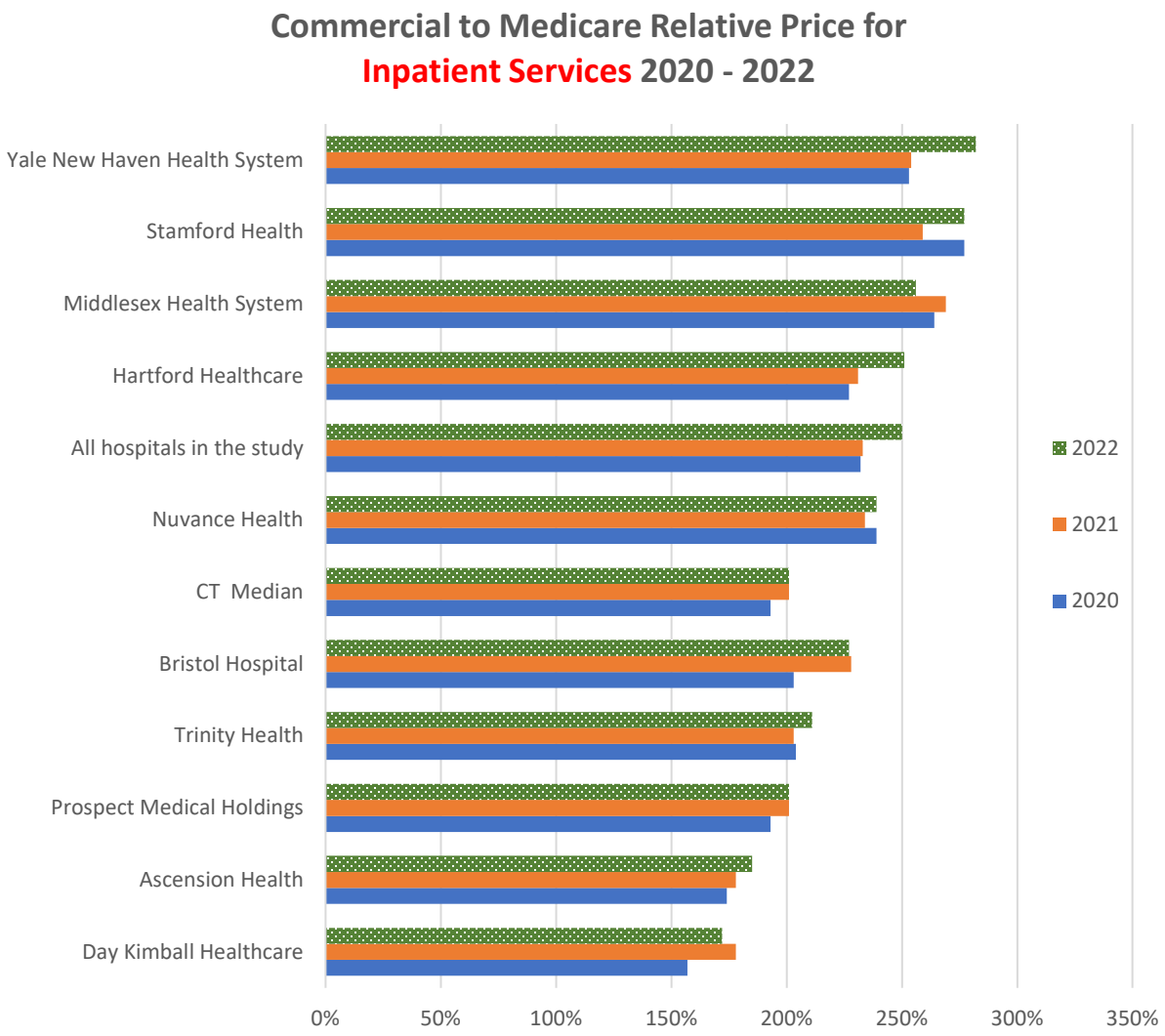
Commercial to Medicare Relative Price for Outpatient Services 2020 - 2022

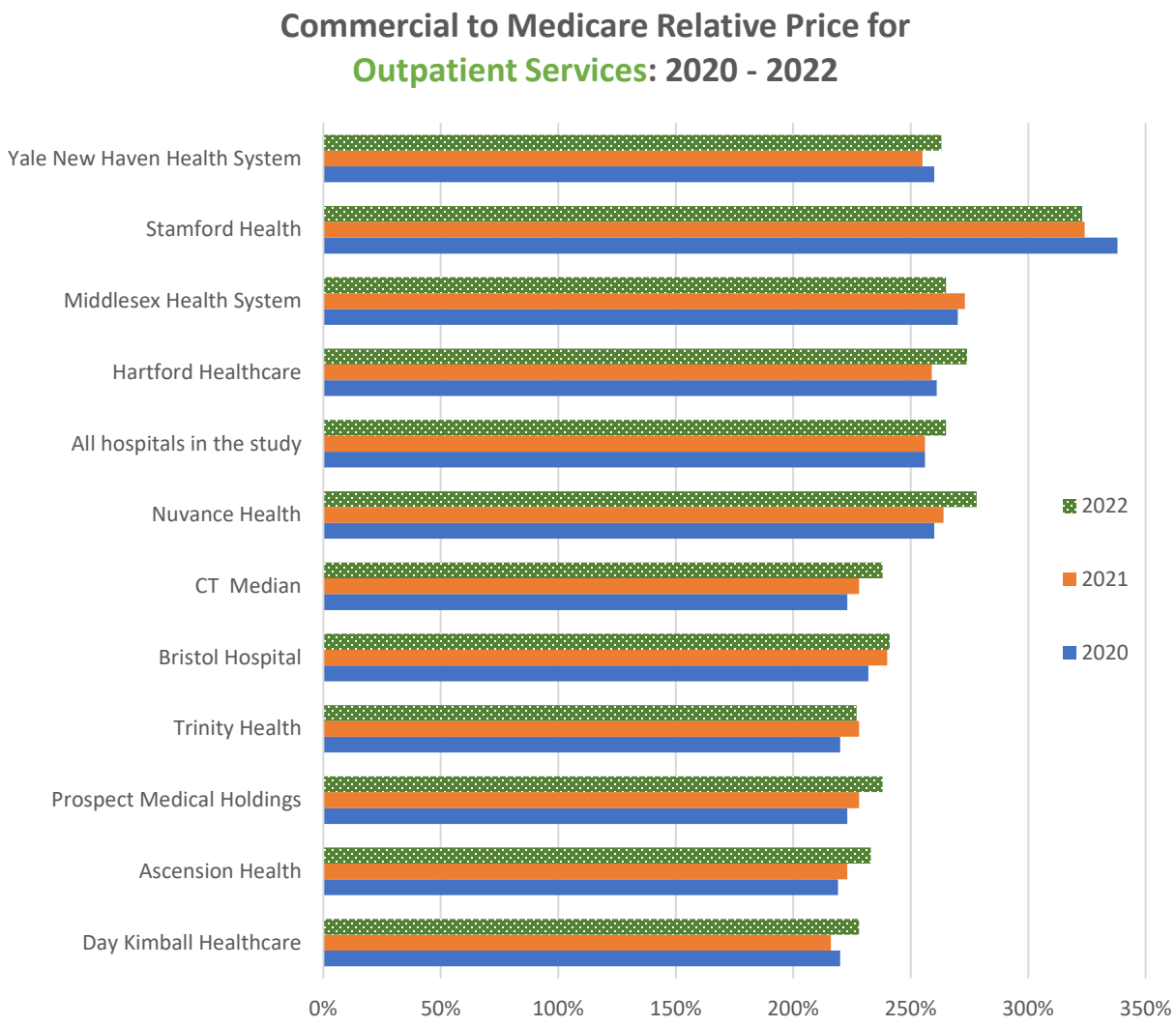


RAND 5.0 Results: CT Hospitals



RAND 5.0 Results: CT Health Systems





Rand 5.0 Results – Observations

- Between 2020 and 2022 commercially insured prices for:
  - Hospital inpatient services
    - Ranged between 168% (Day Kimball Hospital) and 270% (The Stamford Hospital) of Medicare inpatient services prices
    - The statewide median was 185% of Medicare
    - ***Connecticut ranks 21st highest in the nation***
  - Hospital outpatient services
    - Ranged between 159% (Waterbury Hospital) and 329% (Stamford Hospital) of Medicare outpatient services prices
    - The statewide median was 222% of Medicare
    - ***Connecticut ranks 31st highest in the nation***
  - Hospital emergency department services
    - Ranged between 239% (Charlotte Hungerford Hospital) and 445% (William Backus Hospital) of Medicare emergency department services prices
  - Health System services (in 2022)
    - Ranged between 227% (Trinity Health) and 323% (Stamford Hospital) of Medicare inpatient services prices
    - Ranged between 133% (UConn Health Center) and 282% (Yale New Haven Health System) of Medicare outpatient services prices

Reimbursement Rate Analysis Methodology (3 of 3)

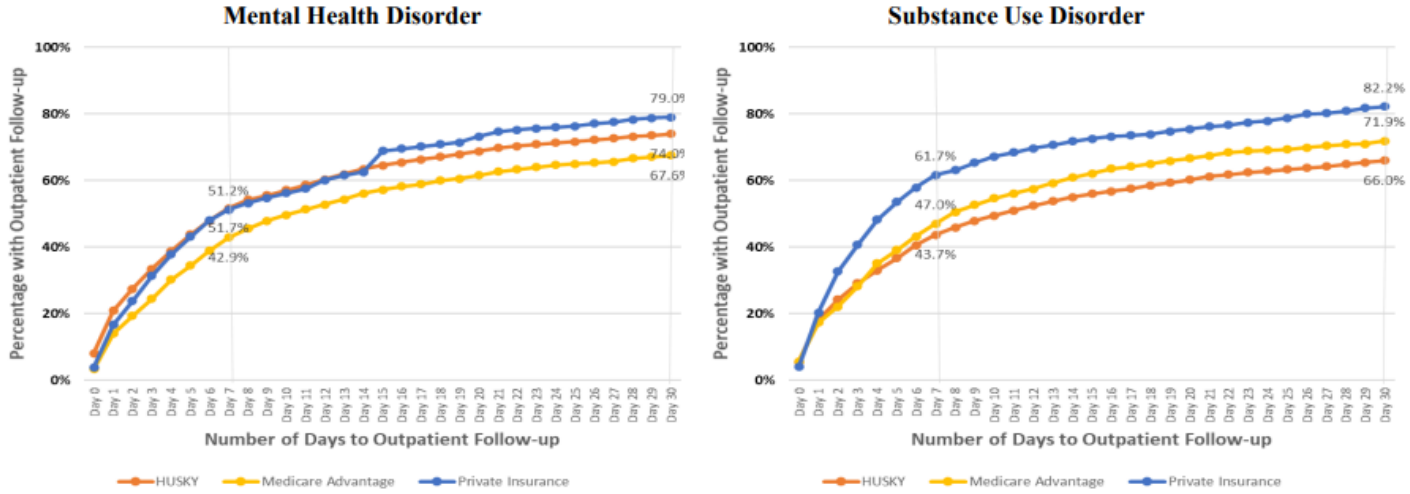
- ***Psychiatrists and behavioral health advanced practice nurses (APNs) and Physician Assistants (PAs) provide a greater volume of office visits***
- ***Counselors, Psychologists, and Social Workers provide a greater volume of psychotherapy service***

Specialty	Number of Providers with Claims for Office Visits	Number of Providers with Claims for Psychotherapy
Psychiatrists	**3,076**	605
BH APNs and PAs	**1,587**	447
Counselors	69	**6,142**
Psychologists	40	**3,369**
Social Workers/BAs/MFTs	178	**12,210**

STUDIES: Behavioral Health Payment Parity

Follow-up* After Hospitalization for MHD and SUD, Ages 6 and Over

- *Rates of follow-up after hospitalization for mental health disorder (MHD) were similar in HUSKY and Private Insurance in the first 7 days following discharge*
- *Rates of follow-up were slightly higher in Private Insurance by day 30 with 79% of Private Insurance enrollees compared to 74% of HUSKY enrollees having an outpatient follow-up visit by day 30*
- *Medicare Advantage enrollees had lower rates of follow-up following hospitalization for MHD*
- *Private Insurance enrollees had higher rates of follow-up after hospitalization for substance use disorder (SUD) than HUSKY and Medicare Advantage enrollees*

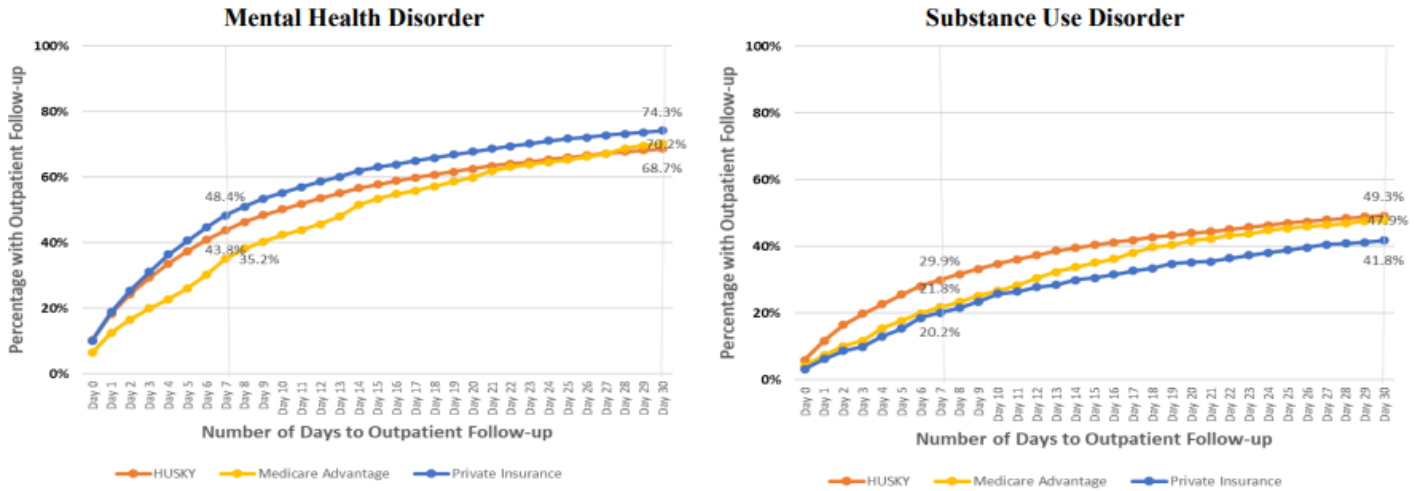


OHS *Includes office-based care and outpatient care, intensive outpatient treatment, partial hospitalization, and residential treatment

STUDIES: Behavioral Health Payment Parity

Follow-up* After Emergency Department Use for MHD and SUD, Ages 6 and Over

- *Rates of follow-up after emergency department (ED) use for mental health disorder (MHD) were slightly higher for Private Insurance enrollees ages 6 and over compared to HUSKY enrollees in the 30-day period following the ED visit (74.3% compared to 68.7%)*
- *Rates of follow-up after ED use for substance use disorder (SUD) were lower than 50 percent for all payers*
- *HUSKY enrollees had higher rates of follow-up after ED in the first seven days following the ED visit (29.9% versus 20.2%) and at 30 days (49.3% versus 41.8%)*



*Includes office-based care and outpatient care, intensive outpatient treatment, partial hospitalization, and residential treatment

STUDIES: Behavioral Health Payment Parity

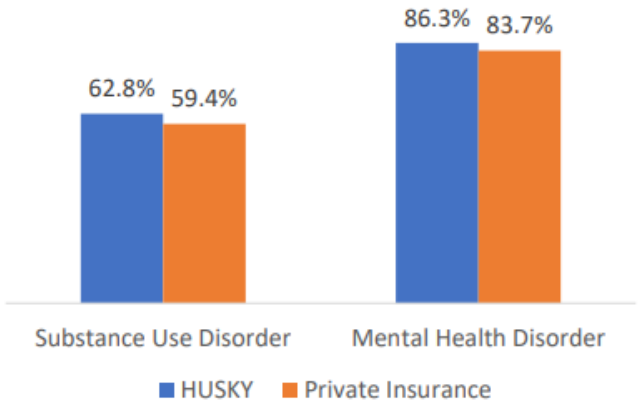
Number and Percentage of HUSKY and Private Insurance Enrollees Ages 12 to 17 with MHD and SUD Diagnoses, and the Number and Percentage with Outpatient Treatment* Among Enrollees with a Diagnosis

- ***Rates of Mental Health Disorder (MHD) among youth ages 12 to 17 were similar in Private Insurance and HUSKY (approximately 25%)***
- ***Rates of Substance Use Disorder (SUD) were higher in HUSKY (1.9%) compared to Private Insurance (0.5%)***
- ***Receipt of any outpatient treatment was higher for individuals with MHD than for individuals with SUD (over 80% for MHD compared to approximately 60% for SUD in both HUSKY and Private Insurance)***
- ***Receipt of any outpatient treatment was slightly higher in HUSKY compared to Private Insurance for both MHD and SUD***

Number and Percentage of Youth Ages 12 to 17 with a Behavioral Health Diagnosis Based on Claims Data

	HUSKY		Private Insurance	
	N	%	N	%
Mental Health Disorder	32,595	25.9%	18,994	25.5%
Substance Use Disorder	2,408	1.9%	374	0.5%

Percentage of Youth Ages 12 to 17 with a Behavioral Health Disorder Who Received Any Outpatient Treatment*



*Includes office-based care, intensive outpatient treatment, partial hospitalization, residential treatment, and medication treatment for SUD

STUDIES: Hospital Community Benefit

In 2010, Congress passed the Patient Protection and Affordable Care Act (ACA) adding requirements for hospitals to keep their tax-exempt status. These requirements were codified in Internal Revenue Code Section §501(r), which require hospitals to:[38]

Complete a Community Health Needs Assessment and adopt an Implementation Strategy every three years.

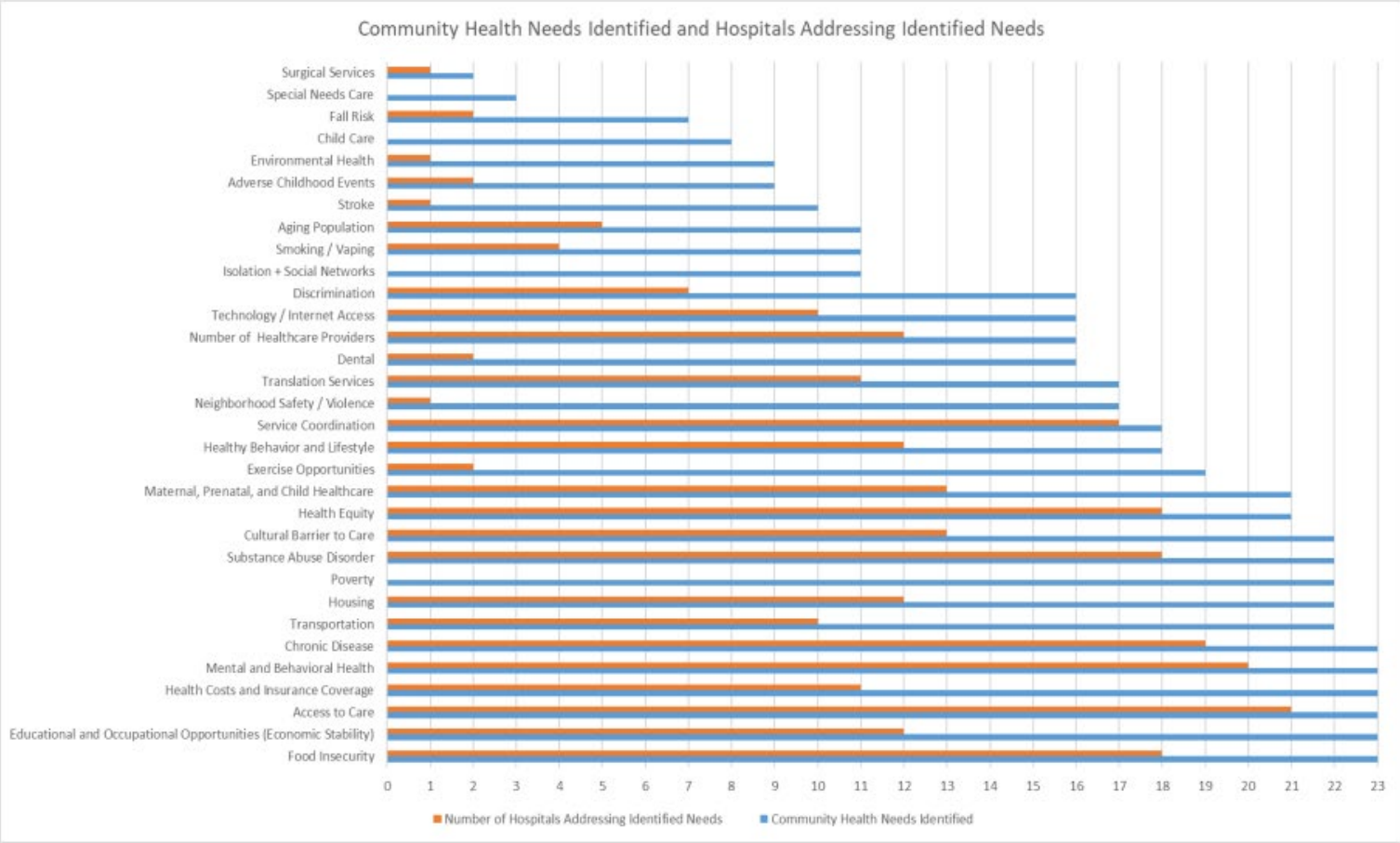
Have a written Financial Assistance Policy (FAP) and Emergency Medical Care Policy.

Limit the amount charged for any emergency or other medically necessary care to a FAP-eligible individual to not more than the amount generally billed to individuals who have insurance covering such care.

Make a reasonable effort to determine whether an individual is eligible for assistance under the FAP before engaging in collection action against that individual.

STUDIES
Hospital Community Benefit

Figure 1: Community Health Needs Identified by Number of Hospitals Addressing Each Need (2021-2022)



1. Mental and behavioral health.
2. Access to care.
3. Food insecurity.
4. Health costs and insurance coverage.
5. Chronic diseases.
6. Education and occupational opportunities (economic stability).

STUDIES

Hospital Community Benefit : Implementation Strategy (details)

Connecticut Nonprofit Annual Status Reports

What is it, and why is it important?

Annual Status Reports were submitted by Connecticut acute care hospitals for filing year 2022 for the first time in 2023. They must include:

1. A description of major updates regarding community health needs, priorities and target populations, if any;
2. A description of progress made regarding the hospital's actions in support of its Implementation Strategy;
3. A description of any major changes to the proposed Implementation Strategy and associated hospital actions; and
4. A description of financial resources and other resources allocated or expended that supported the actions taken in support of the hospital's Implementation Strategy.

STUDIES
Onpoint Collective Impact Behavioral Health Dashboard

About the Collective Impact Initiative

Background

- Funded by Onpoint to support important improvements in health and healthcare through innovation and collaboration
- Conducted annually with guidance and input from Board's Advisory Committee, staff, and clients
- Open to Onpoint clients (and, potentially, other APCD states in the future)

Key Goals

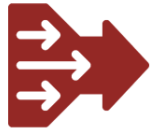
- Leveraging Onpoint's nonprofit mission for the greater good
- Working collectively to have a greater impact
- Highlighting the critical value of APCDs

STUDIES
Onpoint Collective Impact Behavioral Health Dashboard

What are the Goals of the Dashboards?

Visualize

- Trends over time
- Variation during the year



Simplify

- Intuitive interface with some drill-down capability targeted toward public audience

Support

- Improved public and policymaker understanding

Identify

- Areas for additional investigation

ONPOINT Health Data

STUDIES

Onpoint Collective Impact Behavioral Health Dashboard

Collective Impact Dashboards – Key Domains

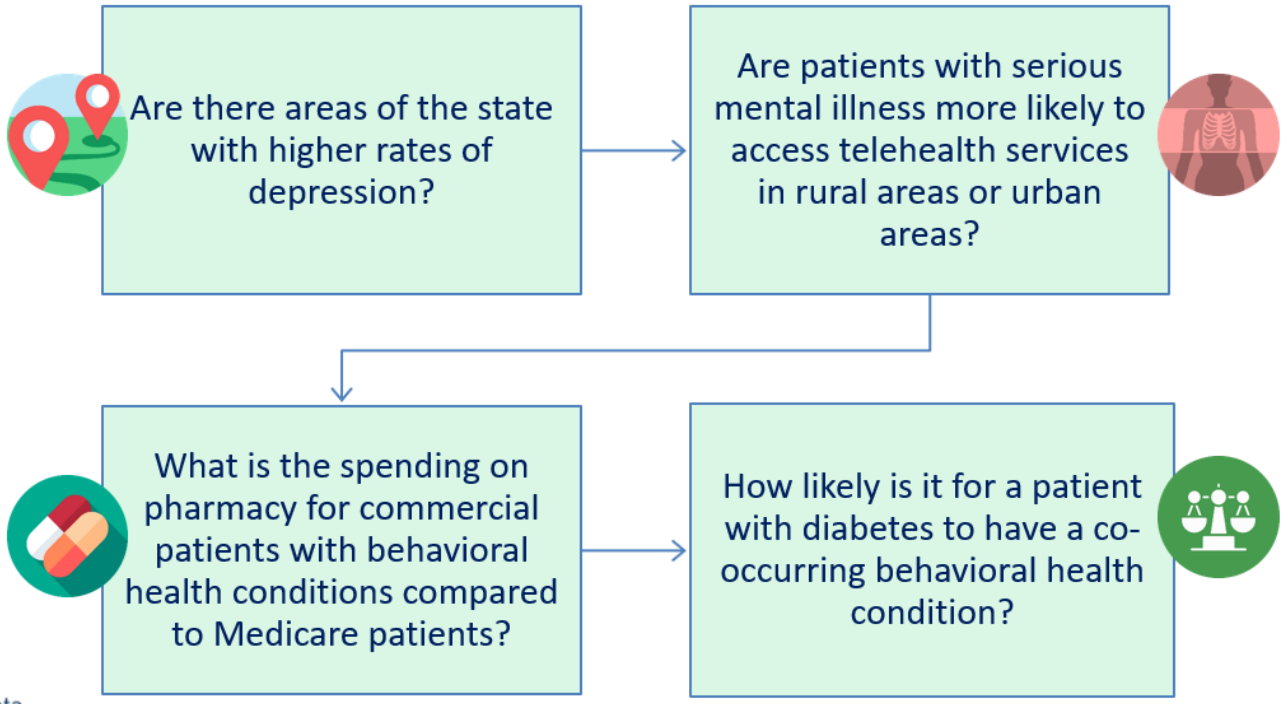
1. Members with Behavioral Health Diagnoses
2. Use of Behavioral Health Services
3. Cost of Behavioral Health Conditions
4. Co-occurring Chronic Conditions

ONPOINT Health Data

STUDIES

Onpoint Collective Impact Behavioral Health Dashboard

What Types of Questions Will the Dashboards Answer?



ONPOINT Health Data

Health IT Advisory Council Update

Sumit Sajnani, HITO

CONNECTICUT

Onpoint Health Data Presentations

Gina Robertson, Sr. Data Analytics Manager

Nathaniel Ferguson, Health Data Analyst

CONNECTICUT

ONPOINT Health Data

Collecting Non-Claims Payments: Key Steps to a Successful Implementation

Gina Robertson, *Senior Data Analytics Manager*

What are Non-Claims Payments (NCPs)?

- NCPs are payments made to healthcare providers or healthcare payers outside of a fee-for-service (FFS) arrangement
- NCP data collection captures healthcare costs not documented in the existing claims or enrollment data submitted to the APCD
- Examples of NCP data:
  - Pharmacy rebates
  - Capitation and full risk payments
  - Population health and infrastructure payments
  - Performance Payments
  - Shared savings and recoupments

Introducing the NCP Data Layout™

- The APCD Council and NAHDO released a national standard for collecting NCP data in April 2024
- NCP Data Layout™ includes three file types:
  1. Annual Payments – collects NCPs made by payers to providers, stratified by payment category and subcategory; follows the Expanded Framework model
  2. Pharmacy Rebates – collects rebates paid by pharmaceutical manufacturers or PBMs to payers, stratified by NDC labeler and product code
  3. Capitation – collects NCPs made by payers to providers for member-attributable services under a capitation arrangement

APCD COUNCIL All-Payer Claims Database
A program of NAHDO in partnership with the University of New Hampshire
Institute for Health Policy and Practice
NAHDO

Introducing the NCP Data Layout™ (cont.)

ANNUAL PAYMENTS FILE				
Data Element #	**Name**	**Type**	**Max Length**	**Description/Valid Values**
CDLAP013	Payment Subcategory	char	2	A1 = Care management/care coordination/population health/medication reconciliation A2 = Primary care and behavioral health integration A3 = Social care integration A4 = Practice transformation payments A5 = EHR/HIT infrastructure payments B1 = Retrospective/prospective incentive payments: pay-for-reporting B2 = Retrospective/prospective incentive payments: pay-for-performance C1 = Procedure-related, episode-based payments with shared savings C2 = Procedure-related, episode-based payments with risk of recoupments C3 = Condition-related, episode-based payments with shared savings C4 = Condition-related, episode-based payments with risk of recoupments C5 = Risk for total cost of care (e.g., ACO) with shared savings C6 = Risk for total cost of care (e.g., ACO) with risk of recoupments D1 = Primary care capitation D2 = Professional capitation D3 = Facility capitation D4 = Behavioral health capitation D5 = Global capitation D6 = Payment to integrated, comprehensive payment and delivery systems X9 = Fee for service Z9 = Member count

Key Considerations Regarding the NCP Specifications

- Which reporting periods will be collected, and how does the reporting period relate to the submitters' reconciliation timelines?
- Do the specifications meet the state's goals and downstream use of the data?
  - Example: NCP Data Layout™ collects payments specific to behavioral health and primary care spend
- Are submitters familiar with the state's goals, timeline, and template?
- How will submitters be supported in understanding and validating the format of NCP data submissions?
- How will NCP data submissions be validated? How long will the validation process take?

Helpful Implementation Steps

Socialize the template with stakeholders

Provide submitter interviews, 1:1 meetings

Incorporate findings into relevant documentation

Prepare a data submission guide, FAQs, validations document

Provide submitters with helpful notice

Implement changes with enough notice to ensure continuity

Offer consistent submitter support

Hold submitter training webinars and office hours

Receive and validate submitters' files

Allow ample time for collaborative validation and iteration

Example: Submitter Interview

Discussion & Questions

Prior to today's call we sent a list of types of non-claims payments, we'll reference the non-claims payments in the excel file and review your responses (e.g., unit of observation). Here are examples of the major non-claims categories:

- Population health and practice infrastructure payments
- Performance payments
- Payments with shared savings and recoupments
- Capitation and full risk payments
- Other non-claim payments

Questions

1. Can you describe the types of non-claims payment arrangements that your organization has in place?
2. Do you include members on the basis on contract situs or state of residency?
3. Could you describe the types of non-claims payment data your organization currently tracks and maintains in its internal data systems?
    - Are there any types of non-claims payment data not listed in the examples above?
    - Do you contract with any other organizations to collect and manage non-claims payments (e.g., a parent submitter)?
    - At what level and frequency is the non-claims data collected? What is a unit of observation (e.g., annual, monthly, per NPI, per TIN, per multiple TINs)
4. Does the information your organization currently tracks contain information about specific non-claims payment types or does it only contain the information about the aggregate information?
    - If there is specific non-claims payment type information, what information is collected?
    - Are you able to provide member months or count of beneficiaries represented in the payment? For an example, if a Payment for Performance (P4P) which incentives are tied to targeted quality measures

Example: Validations Document

ONPOINT Health Data | Support Documentation

AN OVERVIEW OF DATA VALIDATIONS FOR OHCA'S THCE SUBMISSIONS

This document provides an overview of key validations that Onpoint uses to assess the initial quality and completeness of each data submission for the California Office of Health Care Affordability (OHCA) Total Health Care Expenditures (THCE) initiative. Submitters may apply these validations to their data in advance of file submission to remain aligned with Onpoint's and OHCA's technical specifications and standards for quality and completeness.

General File Formatting Checks

- The submission must have a minimum of five files, with a valid code reported in each file's header and trailer (HD003, TR003) to identify each distinct file type (e.g., SWT, ATT, RET, RXR, SQS)
- The header and trailer records for each file must be formatted as described in the Total Health Care Expenditures (THCE) Data Submission Guide (DSG)
- The data submitter code reported in each file's header (HD002), trailer (TR002), and data files must align with the submitter code assigned during registration
- The record count reported in each file's trailer (TR005) must align with the total number of records submitted within each distinct file type (excluding the header and trailer records)
- Each file's format must comply with the file specifications outlined in the THCE DSG. For example, files must be submitted in a text (.txt) format that is pipe ("|") delimited with one row per record.
- All years of data reported for the Period Beginning Date (HD004) and Period Ending Date (HD005) must be included in each THCE file
- The record type field in each file (i.e., the last field, XXX899) must correspond to the file submitted and must align with the file type code reported (i.e., SWT, ATT, RET, RXR, SQS) in each file's header (HD003) and trailer (TR003) records
- Data submitted must comply with each element's data type and length specifications as outlined in the THCE DSG
- Only standard ASCII characters are allowed in each data submission

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Thank you.

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APCD Updates: Data Available

Paul Brady, OHS

CONNECTICUT

APCD DATA TYPES & YEARS AVAILABLE

The APCD comprises medical, pharmacy, and dental* claims information from enrollment and eligibility files

Payer Source	Claim Type	Years Available
Commercial** • **Fully Insured Claims** • **State Employees/Retirees & Municipalities in State Partnership Plan** • **Medicare Advantage (Medical only, no pharmacy)**	Eligibility/Enrollment Medical Claims Pharmacy Claims	1/1/2012 – 3/31/2024
Medicaid	Eligibility/Enrollment Medical Claims Pharmacy Claims	1/1/2015 – 3/31/2024
Medicare* **	Eligibility/Enrollment Medical Claims	1/1/2012 – 12/31/2019
	Pharmacy Claims	1/1/2012 – 12/31/2018

FACT:
As of 2024 the CT APCD contains over 1B records

For Snapshot of Data Available Visit HealthscoreCT

*Denied and dental claims and new REL data collection began January 2024

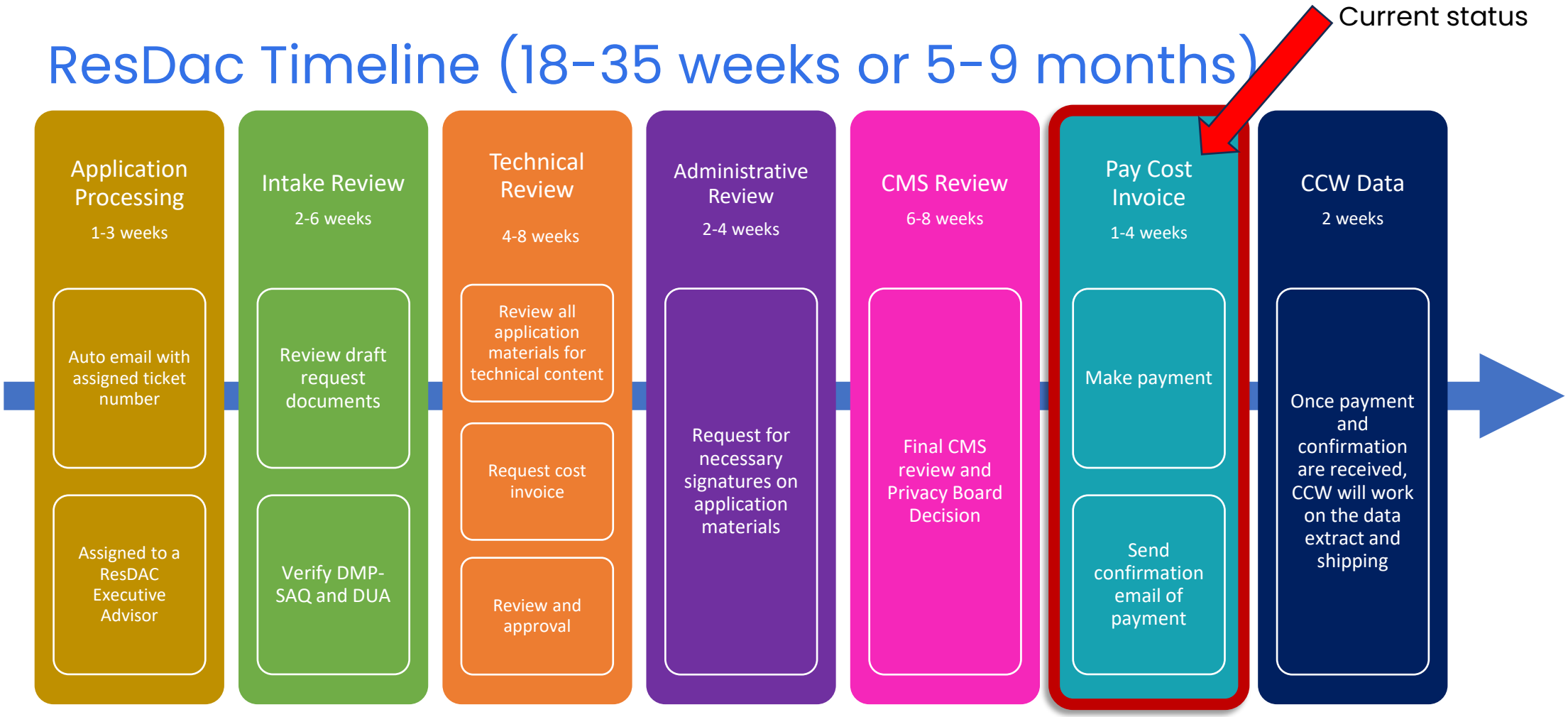
**Anthem (Elevance Health), Aetna, Cigna East, Cigna West, ConnectiCare, UnitedHealthcare, HealthyCT, Harvard Pilgrim, Optum Health, Oxford, WellCare Health, eviCORE Healthcare, Express Scripts, Caremark. Dental carriers: UnitedHealthcare, Ameritas, Elevance Health, Aetna, Cigna, Unum

Reporting threshold – 3,000 members

****Request approved by ResDac/CMS for 2019 – 2022 data*

APCD UPDATES: MEDICARE DATA USE AGREEMENT

ResDac Timeline (18-35 weeks or 5-9 months)



Graphic provided by ONPOINT Health Data

APCD Data Release Committee Report

Dr. Patricia Checko

APCD DATA RELEASE COMMITTEE REPORT

- Data Release Approvals
  - Hospital Community Benefit (3)
  - Silver Hill Hospital (1)
- Data Inquiries (2)
- Other APCD Updates/Inquiries (1)
  - DOJ Antitrust Safe Harbor Review

Wrap Up & Meeting Adjournment

TO REQUEST APCD DATA

To request APCD data for research, policy development/evaluation, or decision-making related to health care services utilization, cost and quality, visit:

https://portal.ct.gov/healthscorect/data-request
or
https://portal.ct.gov/ohs/health-systems-planning/foi/record-and-data-requests