

Issue Brief:
All-Payer Claims Databases: A Key to Healthcare Reform
Suffolk University Law School, December 1, 2009

Background:

The Health Care Quality and Cost Council decided to establish an all-payer claims database (APCD) in order to meet the Council's goals for quality, cost control, and reducing disparities. Unlike the hospital discharge database or an individual health plan's data, an APCD contains claims data from multiple payers for healthcare services rendered by providers across the continuum of care.

The Massachusetts Health Data Consortium is a non-profit organization that promotes health information technology and health information exchange to improve the Massachusetts healthcare system, and has long been a supporter of a robust APCD for the state. The Consortium planned this event so that state officials and other key stakeholders might learn the benefits of the APCD and would consider broadening the existing data release rules.

The agenda was designed to provide background and context for the Commonwealth's role in the national APCD movement, to demonstrate the types of analytics that may be derived from the data, to explore the benefits for cost control and for quality improvement purposes, and to afford some major stakeholders the opportunity to respond to the presentations and comment on the state's APCD. The event was sold out, with more than 200 people in attendance.

Introduction

Ray Campbell, CEO & Executive Director, Massachusetts Health Data Consortium

All-payer claims databases can play a pivotal role in reducing costs and improving quality of care. The movement of states to establish these databases – an effort that is not for the faint of heart – has grown rapidly in recent years, and we believe that federal healthcare reform efforts will accelerate the pace.

This is a natural topic for the Massachusetts Health Data Consortium (MHDC) to address. We co-hosted a national meeting on all-payer claims databases last year, with the National Association of Health Data Organizations (NAHDO), the Regional All Payer Health Information Collaborative (RAPHC), and the University of New Hampshire Institute for Health Policy and Practice.¹

Based on Medicare data alone, The Dartmouth Institute has done phenomenal work on studying geographic variation in costs and quality. It would be hugely valuable to have that research conducted on the under-65 population as well.

¹ [Link to August 2008 Issue Brief]

State and National Efforts to Establish All-Payer Claims Databases

Patrick Miller, MPH, Research Associate Professor, University of New Hampshire Institute for Health Policy and Practice

Craig Schneider, Ph.D, Director of Healthcare Policy, Massachusetts Health Data Consortium

The primary reason for development of an all-payer claims database is to promote transparency. These databases, created by state mandate, consist of medical, eligibility, and other data from public and private payers.²

These databases are essential because other data sources have serious limitations. Medicare data offers a complete picture of care, but with a limited population (the elderly and disabled). Similarly, Medicaid data is complete, but only covers a limited population (low-income and under-served). Hospital inpatient discharge data includes all populations, including the uninsured, but is only a segment of healthcare.

Chapter 58 of the Acts of 2006 created the Health Care Quality and Cost Council in Massachusetts. The legislation directed the HCQCC to establish statewide goals for quality, cost control, and reducing disparities, and to create a consumer-friendly Website. The Council decided to create an all-payer claims database in order to populate the Website, and MyHealthCareOptions (<http://hcqcc.hcf.state.ma.us>) was launched in December 2008.

The Massachusetts database has data from 21 commercial plans, but no data from third-party administrators, Medicare, or Medicaid. It includes eligibility data, provider information, medical data, and pharmacy claims, but not dental claims.

The Massachusetts effort is part of a national movement that is growing rapidly. As recently as early 2005 there were only two states (Maine and Maryland) with APCDs, but now there are seven, with three other states developing programs and another ten seriously interested in creating APCDs. NAHDO, RAPHIC, and MHDC have held four national meetings in the past two years to promote APCDs.

States are undertaking the challenges of establishing APCDs because the data is so valuable for healthcare reform, payment reform, quality improvement, public health, and other purposes. Examples of analytics based on these databases can show policy makers and researchers the following:

- the cost of treating patients for a particular condition by hospital
- price differentials for a procedure by insurer and hospital
- payment rate benchmarking comparing Medicaid to private plans
- disease prevalence of Medicaid patients compared to commercial patients
- prevalence of conditions over time
- costs for different treatment options for a condition
- patient migration between healthcare service areas
- relative price index by hospital

² This presentation may be viewed at [link to Website].

Cost Variation, Payment Reform, and Accountable Care Organizations

Julie L. Lewis, Director of Health Policy, The Dartmouth Institute for Health Policy and Clinical Practice

There is enormous variation in healthcare spending. For example, per capita Medicare spending ranges from \$6039 to \$17,184 (2007 data). This spending variation is an even greater concern because studies have shown that higher spending is not associated with better adherence to clinical protocols.³

The areas of variation are evidence-based quality, preference-sensitive care, and supply-sensitive care. Evidence-based and preference-sensitive have a negative correlation with high spending, but supply-sensitive care has a substantial correlation with high spending. In essence, supply in healthcare creates demand.

The causes of this variation are patient preference (about five percent of the total), malpractice (10%), capacity and payment system (50%), and clinical judgment (about 35%). The drivers of supply-sensitive care are decision-making by clinicians with no clear guidelines. For example, in Massachusetts Medicare spending during the last two years of life varies from almost \$47,000 at North Adams Regional Hospital to almost \$88,000 at Brigham & Women's Hospital.

Per capita Medicare spending is growing faster than three percent in Massachusetts. Why does this growth matter? The 2008 Medicare Trustees' report projects a \$660 billion deficit by 2023 in Medicare. However, if the average rate of growth in spending was reduced from 3.5 percent to 2.4 percent, Medicare would have a savings of \$758 billion, a cumulative savings of \$1.4 trillion.

The principles for delivery system reform include: better evidence to reduce "gray areas", meaningful measures of system performance, the right workforce, engaged patients with informed choice, organizational accountability for capacity/cost/quality, payment for value rather than for volume, and a focus on measurably improving population health.

Our recommended solution is accountable care organizations. The key elements of the accountable care model are local accountability, standardized performance measurement, and payment reform. ACOs can provide or manage patients across the continuum of care, are of sufficient size to support comprehensive performance measurement and expenditure projections, and are capable of distributing shared savings.

The Brookings-Dartmouth ACO Collaborative will pilot the ACO model to develop a replicable model that can be implemented nationwide. The Round 1 pilot sites are in Roanoke, VA, Louisville, KY, and Tucson, AZ.

Improving Quality of Care and Reducing Medical Errors

³ This presentation may be viewed at [\[link to Website\]](#).

Atul Gawande, MD, Director of the Center for Surgery and Public Health, Brigham and Women's Hospital

The deepest struggle in healthcare is not with money or the bureaucracy of insurance companies and government or the fear of malpractice lawsuits (although these factors make our work more difficult), it is with the complexity of what we are trying to do.

There are two reasons that clinicians fail: ignorance and ineptitude. How do we have 6,000 prescription drugs and 13,600 ICD-9 codes and make everything go right? And be attuned to people's needs, with kindness and attention? No other industry has attempted this level of complexity.

There is a bell curve in healthcare, with a wide gap between the best and worst performers. Most providers are grouped in the middle, but that's not what the public thinks – they think the graph looks like a shark fin, with just a few bad apples on the left and almost everyone at the top on the right. And as Julie Lewis noted, the curves for cost and the curves for quality do not match.

One of the most common operations I do is hernia repair. It's not a terribly complicated procedure, it's a bread-and-butter operation, and takes about 45 minutes. My results are that there is a four percent likelihood of complication or failure, which is around the national average. Surgeons at the Shuldice Hospital in Toronto do more of these in a year than I would do in my career, and they have less than a 0.5 percent chance of complication. A study we conducted at the VA found a bell curve with a range from excellent to 25 percent complications – of course, we were not able to release this data.

I have become increasingly convinced that the curves for quality and the curves for cost do not match. The most expensive places are not the best, and vice versa.

Looking at cystic fibrosis care, there are 117 centers of excellence across the country, with evidence-based medical guidelines, super-specialized care, care team organization, performance measures and data collection (aggregated and anonymized until recently), and comparative effectiveness research leading to new protocols. Survival has increased from six years to 34 years during the last few decades. However, even with these systems, there is still a bell curve.

What is the difference between the excellent performers and those in the middle of the curve? I researched cystic fibrosis care for an article comparing the centers in Cincinnati (middle of the pack) and Minneapolis (number one in the US). The difference was not protocols, lower acuity, or a secret drug, but care on the ground. I observed an interaction between Minneapolis center director Dr. Warren Warwick and his teenage patient Janelle.⁴

We learn from their interaction that excellence is the difference between good and great – the difference between a 99.5 percent and 99.95 percent success rate. Lives are lost in

⁴ For a written account of Dr. Warwick's and Janelle's story, please see "The Bell Curve," in *Better*, Metropolitan Books, New York, 2007, pp. 201-30.

these slim margins. The attributes that achieve excellence are diligence (data and focus), ingenuity, communication, and collaboration.

How do we create this kind of care? Can accountable care organizations be the solution?

There is a happy ending to Cincinnati's story. They made their data transparent, visited the Minnesota clinic to learn from them, and they are now in the top 15. Transparency has transformed care. The Minneapolis approach, as excellent as it is, is actually less expensive. Their patients have a lower hospitalization rate and fewer surgeries.

Regarding my article on the costs in McAllen, Texas, one of the unfortunate aspects of that story is that McAllen didn't know they were the most expensive county in the country. Too much healthcare data is flawed and invisible – for example, it is hard to find out the number of surgeries. Did you know that the number of deaths from surgery complications (189,000) is massively higher than the number of deaths from traffic accidents?

We need timely data, county by county, in order to guide us toward improvement. We have timely data by county on unemployment, the consumer price index, and crop yields, but we do not have it for pneumonia prevalence or heart attack incidence. Healthcare data today is like driving a car with the speedometer indicating the average of all drivers three years ago.

Reactor Panel

JudyAnn Bigby, MD, Massachusetts Secretary of Health and Human Services

Tim Gens, Executive Vice President and General Counsel, Massachusetts Hospital Association

Sarah Gordon, Esq., Vice President of Legal Affairs, Massachusetts Association of Health Plans

Mario Motta, MD, President, Massachusetts Medical Society

Moderator: Denise Love, Executive Director, National Association of Health Data Organizations

Secretary Bigby:

Dr. Gawande put it into context – it is not about cost containment or “quality”, it is making sure that teens do not die of cystic fibrosis. Before becoming Secretary, I was a primary care physician. Regarding the comment about the challenges of ineptitude and ignorance, there has been an incredible advancement of knowledge. For example, early in my career (the mid-'80s) we could only manage the complications of diabetes. By the time I became Secretary in 2007, we knew how to manage the disease to avoid these complications. But we were still only being paid for a 15-minute appointment, despite the incredible breadth of knowledge advancement. One of the takeaways from Atul's story of Dr. Warwick is that he did take the time to know his patient.

We have to deal with the systems issues. We need the right outcomes, and we have to be able to measure them. Chapter 58 (the healthcare reform law) led to the creation of the Health Care Quality and Cost Council in Massachusetts, which has created a public Website with cost and quality data from commercial plans. We need timely data and an

all-payer claims database with Medicare and Medicaid as well, but we also need to know what we want to measure.

There has to be provider engagement regarding how to use the information. As to transparency and public reporting, I understand that there is fear among physicians, problems with the data, and attribution issues. We are responsible for the care of our patients. We need system reform so that we can better serve patients.

Sarah Gordon:

MAHP supports transparency and the HCQCC's efforts. We have worked with the HCQCC and the Division of Health Care Finance and Policy to develop the APCD and the associated public reporting efforts. We believe in the purpose of educating consumers and promoting quality improvement, and we want to see reform of the payment system.

Self-insured plans cover about one-half of the commercial population, but they are not included in the Massachusetts APCD. One concern is that plans are asked to submit data using multiple reporting organizations for various purposes. This practice results in duplicative data submissions, and this is time- and resource-intensive. Our recommendation is for one-source data reporting for the APCD. The current database is not being used to its full potential; as we heard today, there are opportunities for broader applications.

The Chapter 305 law calls for more robust data and a broader scope, which would mean the inclusion of self-insured plans and government programs in the Massachusetts APCD. The APCD is essential to achieving the cost control and payment reform agendas.

Mario Motta, MD:

No physician wakes up and says "I'm going to be mediocre today" – we want it to be like Lake Wobegon, where everyone is above average. Quality improvement is about system reform and system improvement, not about individuals.

The Massachusetts Medical Society is in favor of transparency and of being held accountable, as long as the data is fair and accurate. For example, with beta blockers the difference between the best and worst in Massachusetts is 98 percent vs. 96 percent. With such narrow bell curves, there is "noise" and it's difficult to understand what is "quality" and what is not.

The Massachusetts Health Quality Partners database is run well, but we have strong concerns about the Group Insurance Commission's database. In fact, we are in litigation regarding this situation. If the public reporting is being done for quality and not merely for cost control, you will get physician buy-in.

Tim Gens:

There are two well-known quotes on my desk that are apropos: "If you can't measure it, you can't manage it." However, "Not everything that can be counted, counts; not everything that counts can be counted."

The Massachusetts Hospital Association supports transparency, and we believe in mutual transparency – we would like to see the insurance companies become more transparent. MHA has endorsed the Payment Reform Commission’s recommendations, fee-for-service should not be the dominant form of payment, but we recognize that there is not a silver bullet. We need to address the size and risk issues for ACOs, develop the necessary IT systems, and think about how we will pay for the public goods in the healthcare system (e.g., graduate medical education, treating the uninsured, and behavioral health).

Another issue that has to be addressed is that hospitals currently have to answer to too many payers regarding public reporting. These reporting requirements need to be consolidated.

Denise Love:

We have consensus about data as the central piece of healthcare reform in Massachusetts. Let’s also make sure that consumers have a prominent role in our thinking.

Next Steps:

The Division of Health Care Finance and Policy is developing its data release rules for the state’s all-payer claims database. The Consortium supports the transparency agenda, and believes that this data should be made as widely available as possible (while protecting patient privacy and data security). The Consortium is currently in discussions with DHCFP and others to plan a follow-up event that would provide the audience an opportunity for input into the data release rules.

NAHDO, with assistance from RAPHIC, has proposed that Congress direct CMS to provide Medicare and Medicaid data to states that have legislatively-established all-payer claims databases. Legislative language has been sent to Congress for enactment as part of healthcare reform. The Consortium has written letters to Senators Kerry and Kirk in support of such legislation, so that Massachusetts will be able to incorporate Medicare and Medicaid data into its APCD.

Summary compiled by Craig Schneider, Director of Healthcare Policy, Massachusetts Health Data Consortium, January 2010.

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