

Massachusetts Payment Reform:

The Role of a Robust Massachusetts All-Payer Claims Database; Recommendations for Policymakers

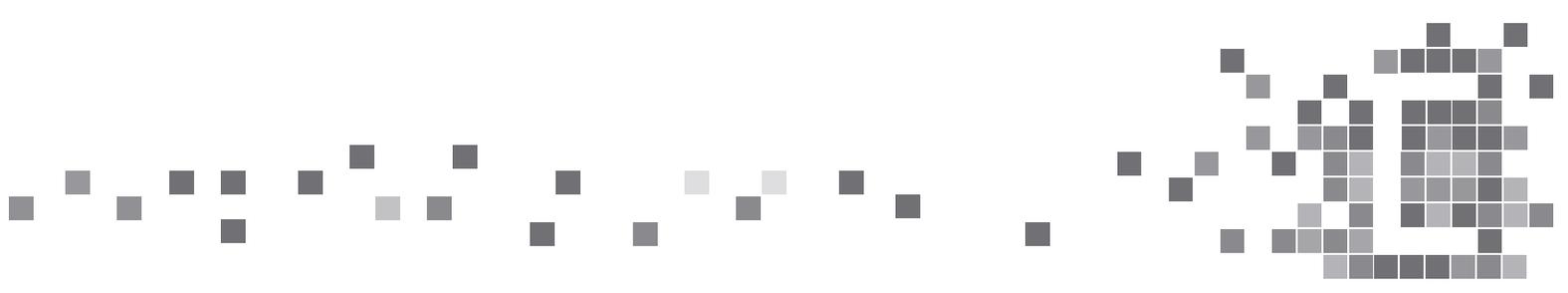
OCTOBER 2011



M|H|A MASSACHUSETTS HOSPITAL ASSOCIATION

The leading voice of hospitals since 1936.

75th
Anniversary



INTRODUCTION

The Massachusetts Special Commission on the Health Care Payment System in its July 2009 report recommended the adoption of a global payment system in the state, and envisioned that, as part of this process, parameters for a standard global payment methodology would be developed, including adjustments for clinical risk, socio-economic status, geography, and other factors. At the same time, voluntarily providers would voluntarily form Accountable Care Organizations (ACOs), which would accept responsibility and take on financial risk for all or most of the care that enrollees need.

The success of these payment reform efforts will depend in large measure on the access to timely, accurate data regarding the costs, utilization and quality of healthcare. Traditionally, healthcare data related to cost, utilization and quality has existed in silos, largely inaccessible across settings of care and between healthcare providers, payers, government agencies, and consumers.

“To determine new mechanisms for the reimbursement of healthcare, it is important to understand the current costs associated with various services, providers, and facilities; the frequency of having those services provided; where care is typically delivered (e.g., physician offices, emergency rooms); and how care aligns to best practice recommendations.”

— All-Payer Claims Databases: An Overview for Policymakers; Patrick B. Miller et al; Robert Wood Johnson Foundation; May 2010

Claims held by healthcare payers represent a vast and rich source of data, which, if accessible and combined with other sources of data, would provide much needed insights into how to shape payment reform, improve quality, and reduce costs.

Numerous states, including Massachusetts, have already created or are now implementing All-Payer Claims Databases (APCDs). All-payer claims databases are mechanisms – created either under statutory authority or through voluntary efforts – to collect payer claims data for purposes of analyzing the cost and performance of healthcare delivery systems.¹ We believe that a robust Massachusetts APCD, which includes the right types of data and provides open and timely access to stakeholders, will become a vital and essential tool, not just for state government but for all stakeholders, that can be used to gain a deeper understanding of the patterns, quality and cost of care across populations.

The administration, in a recent report issued by the Office of the State Attorney General, acknowledges the value and need for provider access to this data:

“To improve care coordination, providers, whether or not they are at risk, need data that enables them to better manage the cost and quality of the care they provide to their patients. This includes data on commercial and government patients, fully-insured and self-insured patients, and HMO and PPO patients. The all payer claims database, which is being developed by the Division of Health Care Finance and Policy (“DHCFP”), should be a repository of all of these types of claims data. Providers should have access to all claims data for patients with a PCP in that provider’s group in order to better manage the cost and quality of the care they provide to their own patients. In addition, providers should have access to detailed statistical and de-identified information for all other patients in Massachusetts in order to analyze cost drivers and identify strategies to improve quality and efficiency.”

— Examination of Health Care Cost Trends and Cost Drivers, June 2011

THE GOALS OF THIS PAPER ARE TO:

- Provide a brief overview of the status of APCD implementation in Massachusetts
- Describe the advantages to hospitals and health systems, as well as other stakeholders, of the creation of the APCD in Massachusetts, highlighting the uses and benefits of APCDs for providers in their efforts to increase efficiency, better coordinate care, reduce cost and improve quality.
- Make recommendations to policymakers for achieving the greatest value from the initiative – with focus on access to data; governance and appropriate stewardship of the data and its use; rigorous maintenance of data quality; and measurement validity, aggregation and interpretation.

¹ See Patrick Miller et al., All-Payer Claims Databases: An Overview for Policymakers (May 2010) (prepared for State Coverage Initiatives by the National Association of Health Data Organizations and the Regional All-Payer Healthcare Information Council).

OVERVIEW AND STATUS OF APCD IMPLEMENTATION IN MASSACHUSETTS

In August 2008, Massachusetts conferred authority, under M.G.L. c. 118G, § 6, on the Division of Healthcare Finance and Policy (Division or DHCFP), to create an APCD with medical, pharmacy, and dental claims, as well as provider, product, and member eligibility information derived from fully-insured, self-insured, Medicare and Medicaid data. Among other objectives, the collection of claims data through the APCD will enable the Division to analyze, among other things:

- Changes over time in health insurance premium levels;
- Changes over time in the benefit and cost-sharing design of plans offered by these payers; and
- Changes in measures of plan cost and utilization.²

The Division issued draft regulations for the submission and release of healthcare claims data in April, held a public hearing in May, and adopted the final regulations in July 2010. The regulations were adopted on an accelerated schedule and provide a framework for the release of healthcare claims data.³ (See sidebar for critical milestones.)

Regulations fall short in addressing the data needs of those outside of government

DHCFP regulations for the APCD address requirements for submission of data by healthcare payers and requirements for parties to access the data. The Division is focused on first building the claims database, then on meeting the many statutory charges for the use of that data by state agencies. However, there is a legitimate question as to how the data needs of those outside government will be addressed. Recognizing this concern, DHCFP held three public forums in May, 2011 to solicit feedback on APCD governance, data release and data use. A priority for consideration is development of an organizational approach that can be used to address those needs, external to government, in the most expeditious way.

² M.G.L. c 118G, § 6.

³ Draft regulations were issued in April 2010, a public hearing was held on May 17, 2010, and the final rule became effective on July 23, 2010.

MHA recommends changing the statutory authorizing provision to establish that all APCD regulatory provisions, including the release and use of APCD data, be subject to approval by a governance committee comprised of a majority representatives from the provider, payer, employer, and consumer communities, and also include representatives from state government.

The guiding principle should be that the Division should release information unless there is clear and convincing evidence that such release would run contrary to laws that protect privacy and patient confidentiality.

All-Payer Claims Database Timeline: Critical Milestones

APRIL 2010 DHCFP issued notice of public hearing and released draft regulations for both collection and release of healthcare claims data

MAY 2010 DHCFP held a public hearing

JUNE 2010 DHCFP applied to obtain Medicare claims data for Massachusetts residents for 2007 and 2008.

JULY 2010 DHCFP adopted final regulations, which addressed virtually all issues raised by stakeholders

OCTOBER 2010 Began collecting self-insured data for cost trends analyses

JANUARY 2011 DHCFP began holding daily Technical Advisory Group Calls to address common submission issues and resolve implementation problems

FEBRUARY 2011 Healthcare payers began submitting healthcare claims data to DHCFP for November 2010, December 2010, and January 2011

MARCH 2011 Payers to submit regular data updates, on a monthly basis

MAY 2011 Healthcare payers will begin submitting all healthcare claims data to DHCFP for 2008, 2009, and the remainder of 2010

MAY 2011 DHCFP holds 3 public forums to obtain feedback on APCD governance and for obtaining and using the data

SUMMER 2011 DHCFP will make data sets available for sister agencies to use and thereby reduce duplicative data requests (promotes administrative simplification)

FALL 2011 Files of data for public use and restricted use will be made available through application process

In July 2010, Chapter 288 of the Acts of 2010, An Act to Promote Cost Containment, Transparency and Efficiency in The Provision of Quality Health Insurance for Individuals and Small Businesses, was signed into law. The new law creates numerous new requirements for cost transparency and the public sharing of information in which the availability of comprehensive, accurate, and robust claims data will be essential. These provisions add significantly to DHCFP duties and responsibilities.

Specifically:

Section 13: Requires the submission of data on inpatient and outpatient costs from payers and providers to be posted on a public website. Information to be posted includes health status adjusted total medical expenses, relative prices, and hospital inpatient and outpatient costs.

Sections 51-53: Directs DHCFP to promulgate regulations to establish a uniform methodology for calculating health status adjusted total medical expenses, relative price, and hospital costs. (Regulations at 114.1 CMR 42.00 implement hospital reporting requirements, and at 114.5 CMR 23.00 implements payer reporting requirements.)

Section 38: Requires payers to post the relative price, Total Medical Expenses (TME) info on their individual websites and include this information in provider directories.

Section 64: Requires DHCFP to foster adoption of bundled payment arrangements.

Section 67: Establishes a special commission to investigate the effect of reimbursement rates carriers pay to providers.

Section 56: References “maximizing the use of a single all payer data base administered by the Division” to streamline state created or mandated administrative requirements including reporting requirements.

MHA suggests there are, at least, three possible approaches that could address fulfilling the data needs of those outside government. Any one of these could address the needs of the private sector entities for access to the APCD. The key will be to bring stakeholders together to develop a consensus on which has the best chance for successful implementation and sustainable operation.

1. One approach would be legislative authorization for a **private health data service bureau** that would serve as the “exclusive” disseminator to private parties. This service bureau would have to negotiate data protection and release procedures with DHCFP and based on those procedures would provide data and reports to private parties such as providers, payers and employers.
2. Another way would be to seek a **coalition of local payers** who would be willing to set up a private data service bureau as a way to reduce their costs of submitting claims data to the state, and then use that dataset to provide data and reports to private parties, such as providers, payers and employers. Procedures to protect and release the data would have to be adopted by the service bureau in compliance with state and federal law.
3. A third option would be for DHCFP to **procure or designate a local non-profit** to be its preferred vehicle for data dissemination to private entities. The designated entity would arrange with DHCFP its rules and procedures for protecting and releasing data and reports.

Whichever approach is settled on, it is important that the following characteristics are adopted:

- It creates, promotes, and supports collaborative efforts to improve health and healthcare using health data and health information technology.
- It demonstrates a multi-stakeholder and consensus-based process for the creation, promotion, and support of health and healthcare improvements through the use of data and health information technology.
- It has a public set of guiding principles that ensure that its process is transparent, and supports nondiscrimination and conflict of interest policies that demonstrate a commitment to open, fair, and nondiscriminatory practices.
- It builds on the transaction standards issued under the Health Insurance Portability and Accountability Act of 1996.

BENEFITS OF APCDS TO PROVIDERS AND OTHER STAKEHOLDERS

All stakeholders can use data from the APCD to assess quality, cost, and efficiency across the continuum of care; providers should place emphasis on measuring the attributes that close gaps in the provider's own information, align provider perspectives with payer perspectives, and help providers navigate payment reform successfully.

Claims data available through the APCD do not detract from the value of providers' clinical data, but they have the substantial benefit of being in electronic form, and thus easier to access⁴.

Such access would enable providers to supplement existing hospital clinical and outcomes data with claims data, which will enable the use of more robust methodologies and analytics.

⁴ We note here the limitations of administrative data: Evaluations of the quality of care used to inform the public, to make purchasing decisions, or to reward/sanction organizations must rely on a complete clinical picture of the patient and the care delivered. Administrative data bases, because of inherent limitations tied to coding systems and methods - among other issues - are unsuited to this use. Quality of care evaluation tools based on administrative databases were designed to be, and are suitable only as, screening tools for use by health care providers to direct their quality management processes. A complete picture of patient conditions and care delivered is available only in the medical record. Measures developed by the federal Agency for Healthcare Research and Quality and employed by private and public reporting agencies (e.g., MA EOHHS) suffer from the deficiencies of administrative databases.

⁵ Massachusetts Executive Office of Health & Human Services website; Researcher > Physical Health and Treatment > Health Care Delivery System > DHCFP Data Resources; <http://tinyurl.com/33rsbj4>.

⁶ See Massachusetts Health Data Consortium, Issue Brief: All Payer-Claims Databases: A Key to Healthcare Reform, Suffolk University Law School 2 (Dec. 1, 2009), at http://www.mahealthdata.org/resources/Documents/20091201_IssueBriefAllPayerClaimsDatabases.pdf; Massachusetts Division of Healthcare Finance & Policy, Presentation, *All-Payer Claims Database Overview 8*, at <http://www.mass.gov/dhcfp/apcd>.

Benefits of Access to the Other Stakeholders

Payers: While payers are the ones submitting their claims data to the APCD, payers will nevertheless benefit from access to the APCD. For instance, access would allow payers to perform some of the same sorts of data measurements and evaluations that providers might seek to perform through benchmarking and other activities. It also enables them to analyze and test changes in payment methodologies.

Consumers/Employers: With access to work product derived from APCD data, they should have the ability to make more informed decisions based on substantiated cost and quality considerations about benefit design and individual healthcare expenditures.

Researchers and Policymakers: Providing access to APCD datasets to researchers and public policymakers greatly expands the types of data available to these constituents. Traditionally, the universe of data available to these parties has been data on Medicare and Medicaid populations, and on certain hospital data in certain states. In Massachusetts, the state maintains a Hospital Inpatient Discharge Database with "case mix and charge data for all inpatients discharged from Massachusetts acute care hospitals" along with "comprehensive patient-level information including socio-demographics, clinic data, and charge data."⁵ However, this database does not provide any information on healthcare system use beyond the hospital.

Consistent with the benefits for other stakeholders, researchers and policymakers can greatly expand the scope, scale, and quality of their analytics. For instance, researchers and policymakers can use APCD data in analyzing, among other things: payment rate and utilization benchmarking, disease prevalence of Medicaid and Medicare patients compared to commercial plans; prevalence of conditions over time; costs for different treatment options for a condition; effectiveness/value of high-cost drugs and technology; per-capita expenditures and utilization for the uninsured⁶ etc.

See footnotes at left.

Over the coming years, all payers will be seeking methods to improve efficiency and quality through the continuum of care. They will be assessing the *total* cost of care using more sophisticated approaches, including the risk-adjusted total cost of care across the care continuum. They will evaluate transitions across providers and the use of non-traditional service-delivery approaches, including group visits, phone care, e-visits, care plans, support groups and coaching, remote monitoring, and enhanced self-care. Payers are likely to use this total-cost-of-care data for network design and provider payment negotiations, and to develop benefit incentives that encourage consumers to use providers they see as efficient and high value. In addition, employers and consumers will continue to become increasingly aware and engaged in healthcare cost issues – employers, due to the challenge of steep increases in premiums; consumers, due to decreases in first-dollar insurance coverage, wages negatively impacted by healthcare costs, the national political emphasis on healthcare regulation, and the prevalence of “wellness incentives” over the past several years. Consumers may be more willing to tolerate narrow networks and provider restrictions.

Given all these developments, providers will need an improved understanding of **total-cost-of-care or total medical expense performance** (TME), and to identify the underlying quality and operational changes that are needed to compete effectively on value – inclusive of TME performance.⁷ Hospitals, for example, will need to understand the type of care that happens outside of the hospital, before and after hospital events, as they seek to identify opportunities to improve collaboration across the continuum, and improve value while reducing total cost of care.

Payers, including administrative payers and employer/government purchasers, have until now been the only entities with the data assets and incentives to assess the total cost of care for any type of condition or service, and to understand the quality issues that are the result of single entity or cross-entity care. Hospitals and other providers will have the opportunity to use APCD data to understand these issues.

In order to tap into the potential of the APCD data, providers will need the staff (with clinical and financial analysis skills) and data management capabilities that will enhance their ability to construct and analyze episodes of care, to apply and interpret risk adjustment, to understand emerging patient demographics and new treatment patterns, to understand and apply the various methods of provider attribution, and to model the implications of new payment and risk sharing models.

Individually, and combined, episode of care and risk adjustment methods form the foundation for efficient linkage of clinical analytics and financial analytics, creating a bridge between risk management and care delivery perspectives. An episode total cost of care model is useful for describing actual historical costs; risk adjusted cost models are useful predicting future costs. Risk adjusters can be used to identify specific population subsets for targeted proactive management, with the objective of mitigating high costs and escalating illness.

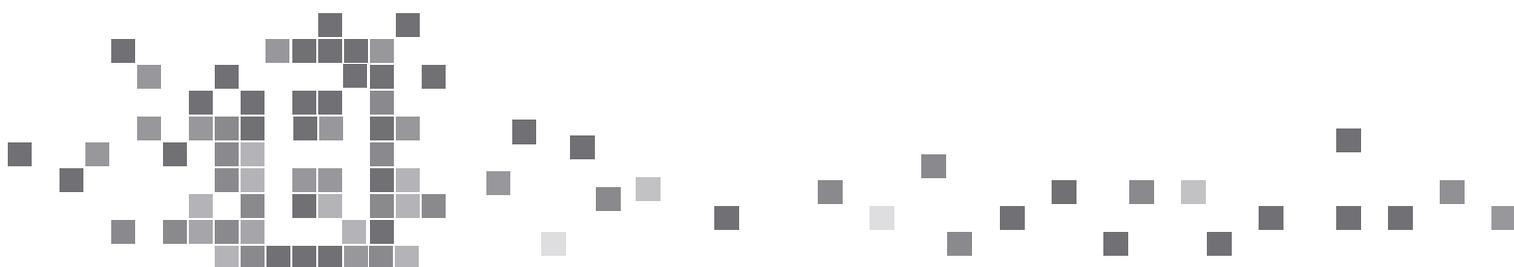
Some reasons why APCDs can be useful for this purpose include those outlined below:

- **Access to Data Not Previously Available to Providers:** Hospitals and others can currently only measure partial attributes of healthcare performance with their own data and with access to other data that is limited to discrete populations (e.g., Medicare/Medicaid), but no individual stakeholder has the ability to see the complete picture of the opportunities for value-enhancement to healthcare delivery without contextual information from a full data set.

In Massachusetts, the Division of Healthcare Finance and Policy maintains a Hospital Inpatient Discharge Database with “case mix and charge data for all inpatients discharged from Massachusetts acute care hospitals” along with “comprehensive patient-level information including socio-demographics, clinic data, and charge data”⁸ However, this database does not provide any information on healthcare system use beyond the hospital.

⁷ Sections 13 and 51 of c288, mandate DHCFP to collect and publish TME data for medical group practices by zip code. Providers will need the claims detail from the APCD to understand and analyze comparative differences.

⁸ Massachusetts Executive Office of Health & Human Services website; Researcher > Physical Health and Treatment > Health Care Delivery System > DHCFP Data Resources; <http://tinyurl.com/33rsbj4>.



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 care⁹. The APCD can therefore provide never-before-available information about the delivery of care for individual patients across care settings and over time that will fill in the gaps about episodes of care, especially pre-and-post inpatient hospital care and can help identify gaps or failures in care delivery outside of the hospital inpatient setting. In addition, pre/post hospital care data can paint a picture of patient health status that will be valuable for the purposes of risk-adjusting inpatient hospital care outcome measures, by identifying pre-existing conditions, etc.

APCDs generally collect data from within the insurance claims and reimbursement system from various payers and include patient and provider demographics, and clinical (e.g., diagnosis), financial (e.g., paid and charged amounts, coinsurance, etc.) and utilization data.¹⁰ A centralized data collection effort provides standards and common specifications that result in uniform, comprehensive data sets. In particular, the data will allow the creation of benchmarks by providers at multiple levels:

- Procedure and inpatient stay level
- Episode of care level – including pre- and post- inpatient care data (see sidebar*)
- Condition level – for example, the treatment of patients with diabetes, across multiple episodes, including primary management and treatment of complications

Thus, the APCD can facilitate analysis from high-quality, consistent claims data that are not generally or easily available to providers (e.g. information regarding outpatient encounters with physicians and other non-hospital providers).

- **More Robust Analysis of Cost Data:** Achieving a more value-based healthcare system requires the ability to understand cost performance in a manner that is clinically actionable, strategic, timely, reliable, and accurate. Access to APCD data sets will provide an opportunity for more robust data measurement and analysis. If such access is available in a meaningful way, hospitals (and other stakeholders) can use it to realize value from the current healthcare payment system and the impending reforms that are likely to be made to it.
- **More Sophisticated Analysis of Performance Data:** Quality is also an integral part of any value-based healthcare system. The APCD will allow hospitals to leverage additional data that will help them not only to understand current quality levels, but also to undertake appropriate, targeted efforts at improving quality. APCD data should allow a hospital to analyze its own system performance, and also to compare itself with other comparable facilities in its service area (or other similar service areas) on the basis of both efficiency and quality.

For many providers, these types of benchmark measurements will provide new information that could spur innovative and competitive responses to increase efficiency and improve quality. For example, hospitals could use analyses from APCD data (along with other hospital data) to analyze patterns of care and costs, develop prevention programs, or more appropriately match individual patient care needs to a proper setting and delivery of that care. This not only increases quality at a lower cost, it is likely a better experience for the patient, which can increase positive outcomes. Furthermore, over time, data measurement can be used to address variability in clinical practice which, with the advent of greater provider accountability, will be essential.

- **Reduction in Administrative Costs:** The APCD could reduce administrative costs for payers; it could also shift the cost of data standardization and analysis from providers and payers to a competent entity that serves the entire market. For instance, the APCD can support the development of more standardized administrative processes across providers, including uniform authorization and referral rules across payers (with automation of some of these rules) and common reporting requirements and formats across payers.

⁹ See Massachusetts Health Data Consortium, Issue Brief: All Payer-Claims Databases: A Key to Healthcare Reform, Suffolk University Law School 2 (Dec. 1, 2009), at http://www.mahealthdata.org/resources/Documents/20091201_IssueBriefAllPayerClaimsDatabases.pdf; Massachusetts Division of Healthcare Finance & Policy, Presentation, All-Payer Claims Database Overview 8, at <http://www.mass.gov/dhcfp/apcd>.

¹⁰ See Miller, All-Payer Claims Databases: An Overview for Policymakers, *supra* note at 3.

Episodes of Care

Episodes of care reflect patient experience of treatment, moving across settings and treatment providers. One patient can have many conditions, and many episodes. Episode groupers use complex clinical and statistical logic to group individually billed services, over time, across providers into meaningful units of study that are: 1) clinically meaningful, 2) financially robust 3) process revealing. Notably, “[a]fter 2 years of study with Medicare claims data, MedPAC concluded that episode groupers have face validity from a clinical perspective, can identify practice patterns, and have risk adjustment capabilities that can account for differences in disease severity and the presence of co-morbidities.”¹¹

Episodes allow the attribution of care to individual physicians – so that we can study the care directly delivered by the physician, as well as the prescribing, hospital, and referral patterns of that physician. Episodes allow attribution of care to hospitals, and to study pre- and post- hospital treatment care. This information can be used to improve coordination across settings, identify and eliminate waste, and to align incentives.

Episodes help identify specific changes in practice that can improve cost efficiency – by capturing the multiple ways services are combined and substituted to produce outcomes

Episodes create a unit of financial analysis that can be linked to clinical outcomes and health status – to drive toward value measurement.

Episodes allow a payment framework that aligns incentives for payers and providers – paying for value rather than volume.

¹¹ Medicare Payment Advisory Commission, 2007

• **Other Benefits:** The APCD, if it provides appropriate access to providers, lays the groundwork for aggregating claims data from the database with data available in electronic clinical records maintained by providers. This sort of aggregation of electronic data could be extraordinarily powerful, not only with respect to the scope, scale, and integrity of the data, but also with the potential analytics that would be possible. Thus, as the APCD becomes accessible and the use of electronic clinical records expands, hospitals and other providers will have more of what they need: accurate, timely information about cost and quality performance in the delivery of care. In addition, many Massachusetts Hospital Association (MHA) members make healthcare information available to their patients and families through portals or other electronic means. The APCD provides an opportunity to enhance the information shared with patients and to develop web tools that provide greater value to patients and providers and result in more appropriate care (e.g., through follow-up after an encounter or other means).

What Providers Can Measure Using APCD

Outlined below are broad categories of information that can be produced using the APCD defined data set, with an explanation of how the APCD enhances existing assets, and how hospitals can use this information.

Measurement Method & Units of Analysis	APCD Enhancements to Current Hospital Capabilities	Potential Uses Improve Hospital Value Position
<p>Resource Use & Total Cost of Care</p> <p>Aggregate, and</p> <ul style="list-style-type: none"> By DRG By Episode By Condition By Physician / Physician Group By Payer <p>Hospital-specific processes</p> <p>Compared to other hospitals;</p> <p>Hospital services compared to alternative delivery sites</p>	<ul style="list-style-type: none"> • Provides access to comprehensive claim data, including pre & post admission treatments and costs • Creates the ability to analyze the variation and impact of different physician and physician groups with admitting privileges based on their pre-admission and post-discharge care • Creates the ability to analyze services provided in alternative settings at different levels of acuity and costs 	<ul style="list-style-type: none"> • Collaborate with physicians to identify gaps, redundancy, and inefficient treatment sequences. • Improve margins by reducing expenses and redundancy across hospital and clinic care. • Collaboratively identify new opportunities for hospitals to improve care and cost, thereby creating revenue stream under new incentive models • Modify physician recruitment and admitting privileges to favor efficient high quality providers. • Identify strong partners for risk-based contracts, global payments, and ACO strategies by combining TCOC studies with existing data on quality performance • Align incentives around high-cost technology capabilities such as MRI, CT, PET. • Right size community capabilities to maximize margin through appropriate use - not overuse. • Study the impact of alternative payment arrangements on hospital revenue and margin.
<p>Patient Demographic Analysis</p> <ul style="list-style-type: none"> By Service Line By Payer By Geography By Physician/Group 	<ul style="list-style-type: none"> • Creates the ability to study market-specific patient illness burdens and treatment patterns more comprehensively, to improve the understanding of needs not traditionally served within the hospital 	<ul style="list-style-type: none"> • Apply population demographic projections to existing risks, treatment and condition patterns to improve capacity planning and investment decisions • Design capacity for local settings, to improve patient experience and market share

Measurement Method & Units of Analysis	APCD Enhancements to Current Hospital Capabilities	Potential Uses Improve Hospital Value Position
<p>Patient Illness-Burden Analysis</p> <p>By Service Line</p> <p>By Payer</p> <p>By Geography</p> <p>By Physician/Group</p>	<ul style="list-style-type: none"> • Creates the ability to more comprehensively score patient illness burdens by providing broader insight into patient diseases than currently available in hospital data systems 	<ul style="list-style-type: none"> • Improve patient insight and market segmentation capabilities • Customize pre-admission and post-discharge plans based on illness burden • Develop strategies for new patient-centered services and capabilities that enhance loyalty, and non-traditional revenue sources • Develop approaches to predict adverse events, and design proactive interventions to prevent and mitigate them.
<p>Post discharge processes, services, costs, quality and complications</p>	<ul style="list-style-type: none"> • Ability to analyze post admission complications and quality issues that do not result in readmissions • Ability to analyze post admission patient adherence to medications and follow up visits • Ability to design and experiment with models that would provide predictive capabilities for identifying those likely to have post-discharge complications 	<ul style="list-style-type: none"> • Collaborate with physicians to improve patient transitions, to improve discharge planning, follow-up, patient adherence, early identification and treatment of complications in an outpatient setting • Align incentives and improve the fragmentation that currently exists for pre and post discharge care - implemented partially by payers, hospitals, and providers • Design, modify and standardize treatment and process protocols based on their impact on post-discharge quality and costs • Modify physician recruitment and admitting privileges to favor high quality providers • Create improved processes and services that lower total cost of care through the reduction in post-discharge complications
<p>Pre-hospitalization processes, services, costs, efficiency and planning</p>	<ul style="list-style-type: none"> • Ability to analyze pre-admission processes to identify patterns that ensure more efficient effective care during the hospitalization 	<ul style="list-style-type: none"> • Study the relationship between different types of pre-visit care on the overall effectiveness of the admission (quality and efficiency), and identify best practice • Collaborate with physicians to ensure, and incent, pre-admission preparation to ensure efficient inpatient stay - lower length of stay, fewer resources = improved margin

OBSERVATIONS AND RECOMMENDATIONS ON THE OPERATIONAL ASPECTS OF THE MASSACHUSETTS APCD

In this section of the paper, we make observations and recommendations relative to administration of the APCD that will be critical if the state is to achieve the greatest value from it and if the APCD is to fulfill its potential as a resource as we transition a to global payment system.

We will focus on four operational aspects: Access to Data, Governance, Data and Systems Quality; Measurement Validity, Aggregation, and Interpretation.

A. ACCESS TO DATA

MHA is supportive of the transparency enabled by the APCD and appreciates the value of making the data available for access by, among others, researchers and policymakers, providers, payers, employers, and consumers. Each of these stakeholders stands to gain in unique and important ways from the data that will be available through the APCD. While MHA wholly supports reasonable and appropriate access by all relevant stakeholders, there are important considerations in providing access to any stakeholder applicant who requests the release of APCD data. As discussed below, the Massachusetts APCD regulations are not entirely clear on the boundaries that may or may not exist with regard to the release of data.

MHA Observations and Recommendations on Regulations on Access to APCD Data

The Massachusetts regulation provides for the release of public use files and restricted use files (see sidebar on page 10).¹² While the regulations provide a necessary framework for the release of data, MHA is very concerned that provider access to the APCD be facilitated.

In addition to the above, the regulation provides for the establishment of a Data Release Committee to be comprised of representation of healthcare plans, providers and consumers. The Committee is charged with, among other things, advising the Commissioner of the Division on individual applications for claims data and providing advice on best practices regarding claims data release and data protection policies. Any decision of the Commissioner to approve or deny an application is final and not subject to appeal or further review.

In this regard, **MHA offers the following observations and looks forward to working with the Division as the agency issues further guidance on parameters for data release.**

- First, the regulations require applicants to, among other things, specify security and privacy measures that will be taken in order to safeguard patient privacy and to protect unauthorized access to or use of APCD data.
 - » ***It is not clear from this provision what privacy and security measures will pass muster for any one applicant or whether there will be a common set of privacy and security requirements that applicants will need to satisfy in order to obtain APCD datasets.*** While a one-size fits all approach may not be appropriate, MHA recognizes adherence to all applicable federal and state privacy and security laws is required for the APCD data sets. The Division currently employs long-standing policies and procedures to protect sensitive data in the hospital discharge data set. The same level of scrutiny and security would not be unreasonable to be applied for the APCD data.
- Second, under the regulations, applicants must agree to provide the results of their analyses, research or other product containing the data requested to the Division for the Division's own use.
 - » The regulations do not identify with any specificity what is intended by "results." ***Does this require full-scale production of all work products containing the data, or is the intent more circumscribed?***
 - » Further, ***if the APCD data are combined with proprietary data obtained from other sources, is there any mechanism available for non-disclosure by the applicant of the proprietary data? Alternatively, will there be a process for the applicant to declare certain aspects of the results confidential and, thus, not subject to public disclosure by the Division?***

¹² Public use files are datasets derived from records submitted by payers that contain de-identified member and utilization data elements and exclude payer identifiers. ¹⁴ Code of Massachusetts Regs. § 22.02. Restricted use files are datasets derived from records submitted by payers and appear to contain identifiable data elements or elements that would permit patient identification.

Overview of Access Provisions in the Data Release Regulation

Stakeholders that wish to access the public use or restricted use files must submit an application that satisfies certain requirements, including that the applicant, among other things:

- specifies the data requested, including public use files and any restricted data elements;
- specifies the purpose and intended use of the data requested, including a detailed project description that describes any other data source to be used for the project;
- specifies the security and privacy measures that will be undertaken in order to safeguard patient privacy and to prevent unauthorized access to or use of such data;
- specifies the applicant's methodology for maintaining data integrity and accuracy;
- describes how the results of the applicant's analysis will be published;
- agrees to provide the results of all analyses, research, or other product of the data requested to the Division for the Division's own use;
- agrees to data disclosure restrictions identified in the regulation;
- obtains prior approval from the Division to release any reports that used restricted use files prior to the publication or other release to another person or entity.¹³
- the applicant's intended use be in the public interest;
- the applicant demonstrate that it is qualified to undertake the study or accomplish the intended use; and
- the applicant requires the data in order to undertake the study or accomplish the intended use.¹⁴

¹³ 114.5 Code of Mass. Regs. § 22.03(2)(a)(1).

¹⁴ Id. § 22.03(2)(b).

» During the public forums, DHCFP staff indicated a willingness to reconsider this language by reducing the level of “editorial” control and to distinguish between data used for academic/research purposes versus practical real time use by providers and others.

- Third, the regulations provide that data that is requested from the APCD must be for a purpose that is in the public interest. While not an exclusive set of examples, the regulation identifies the following purposes as in the public interest: Health cost and utilization analysis to formulate public policy; financial studies and analyses of provider payment systems; utilization review studies; Health planning and resource allocation studies; and studies that promote improvement in healthcare quality or a mitigation of healthcare cost growth.
 - » ***These examples provide some indication of the parameters surrounding release of data from the APCD, but it is altogether unclear whether and how other purposes will be evaluated.*** For instance, will access the APCD data be approved as in the public interest if data are necessary and appropriate for analyses by providers to assess the feasibility of accepting global payment offerings or the opportunity for improvement of care or cost savings for local populations? What about in the case of litigation or government investigation (e.g., antitrust; fraud and abuse; etc.)? Would the government have access in circumstances when the private sector would not? These are important issues given that the regulations do not provide any right to appeal a decision to approve or deny the release of claims data; we anticipate more from the Division when data is ready for public release and application forms and instructions are made available.
- Fourth, the Data Release Committee is charged with providing advice on best practices for claims data release and data protection policies.
 - » While the Committee is to have representation of healthcare plans, providers, and consumers, ***the regulations do not make clear the extent of that representation, its voting capacity or influence.***
 - » Furthermore, the Committee appears to be solely an advisory body to the Commissioner, who has ultimate power to approve and disapprove applications, best practices, and other recommendations of the Committee. MHA encourages the Division to consult with stakeholders, including providers, to further define the governance structure and capacity of this Committee.

Providing the Division with “results” of analysis, research and other product containing data is an overreaching restriction that may limit effective use of the APCD. Similarly, limiting use of the APCD to the “public interest” as defined by the Division is a very broad delegation of authority that may unduly restrict use of the APCD.

MHA recommends changing the statutory authorizing provision to establish that all APCD regulatory provisions, including the release and use of APCD data, be subject to approval by a governance committee comprised of a majority representatives from the provider, payer, employer, and consumer communities, and also include representatives from state government. The guiding principle should be that the Division should release information unless there is clear and convincing evidence that such release would run contrary to laws that protect privacy and patient confidentiality.

B. GOVERNANCE

The Division of Healthcare Finance and Policy has done extensive work on the development of the APCD and is in the best position of any state agency to carry out the responsibility for collecting and maintaining this information. To reduce duplicative administrative costs and ensure the efficient use of limited healthcare dollars, **this responsibility should continue to be housed with the Division, and not transferred to any other state agency.**

That being said, while the Division has legal authority to collect data for the APCD and access to the data is governed by applicable statutory privacy and confidentiality provisions, **it is essential that the agency continue engaging with external stakeholders to inform its processes and decisions.** This is so that a vehicle or nexus is created to provide the necessary buy-in from stakeholders, ensure appropriate use and protection of the data, and to secure the maximum potential from the creation of the APCD.

As it proceeds with APCD implementation, **the Division should consider adoption (formally or informally) of an open and inclusive public-private partnership with a consensus-based process for setting the scope and priorities for the ongoing administration of the Massachusetts APCD.**¹⁵ The consulting group, Booz Allen Hamilton, recommended a “roadmap” to national hospital groups to guide key decisions related to the governance framework, including the organizational framework, the process for building consensus, and priorities for taking action on quality reporting.¹⁶ The guidance is also relevant to APCD and is described in detail in the box below.

Public-Private Partnership: According to a report commissioned by the American Hospital Association, the Federation of American Hospitals and the Association of American Medical Colleges, an inclusive public-private partnership is one that meets the following construct:

“A single organizational framework is needed to delineate the leadership, membership, structure, and operational roles and responsibilities essential to: define, specify, and manage a consensus-driven process; promulgate the business rules; manage stakeholder relationships; and monitor the outcomes of the data collaboration and reporting system. A public-private partnership is a collaboration between public agencies and private industry where the skills, expertise, and assets of each are shared in delivering a service for the ‘public good.’ The public-private model could maximize the limited resources in both sectors and ensure flexibility and adaptability in managing changes in healthcare delivery. It is important to create a partnership that supports the highly collaborative, intensely integrated approach required to develop and maintain an effective quality reporting system that yields the desired results.”¹⁷

¹⁵ For examples of such bodies, see the Tennessee Health Information Committee and the Utah Health Data Committee, discussed below.

¹⁶ See Booz Allen Hamilton, White Paper, *Envisioning the Roadmap for Nationwide Hospital Quality Reporting* (June 2006) (submitted to the American Hospital Association, Federation of American Hospitals, and Association of American Medical Colleges) [hereinafter Booz Allen White Paper], available at <http://www.boozallen.com/media/file/nationwide-hospital-quality-reporting.pdf>.

¹⁷ Booz Allen White Paper, supra note 18, at 17.

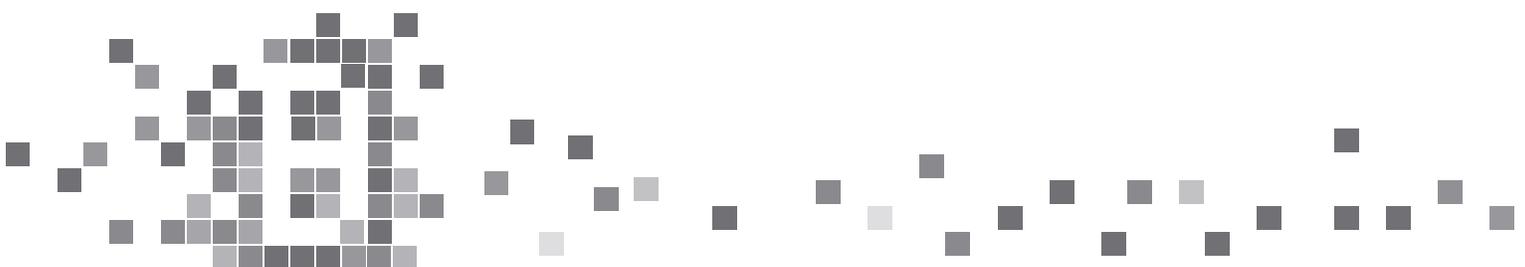
The report further provides that the following best practices are necessary for successful public-private partnerships:

Critical Success Factors	Description	When Present... (Best in Class Examples)	When Lacking...
Trust	Successful partnerships share a common trait: a reputation for trust and confidentiality	The parties freely share information and discreetly protect sensitive information	Participation is selective, information does not flow between the parties, and mistrust grows
Shared Vision	A shared vision of the partnership's "grand purpose" creates common goals, consensus, and an open dialogue	The partnership is positioned to achieve its purpose and produce valuable results	The lack of consensus creates a vicious cycle where participation wanes
Leadership & Commitment	The advocacy and commitment of leaders fosters a shared vision and ensures that resources and expertise are available	Partner members are empowered and re-sourced to address the core needs of the partnership	The partnership will atrophy as the level of contributions from the parties suffers
Flexibility & Adaptability	Successful partnerships evolve over time and demonstrate the ability to adapt	A partnership stays current with the times, adjusting to new conditions (threat, business, technology)	The partnership will become a "snapshot" in time: static, antiquated, and/or rigid
Independence	Independent and unbiased entities fairly protect the interests and equities of all parties	A partnership is viewed by all parties as an honest broker with no hidden agenda	Parties begin to question whether the partnership is unbiased and objective
Results	Successful partnerships require technically competent experts to generate timely/actionable results	Subject matter experts and competent analysis produces valuable results for the parties	The lack of tangible results lead to an erosion of support

Source: Booz Allen Hamilton, *White Paper, Envisioning the Roadmap for Nationwide Hospital Quality Reporting, Exhibit 6: Best Practices for Public/Private Partnerships (June 2006)* (submitted to the American Hospital Association, Federation of American Hospitals, and Association of American Medical Colleges).

Rules for engagement in the public-private partnership must be explicit to ensure the integrity of the decisions. These rules should address the need for transparency, openness, stakeholder representation, balance, and due process, and should recognize that the membership of the partnership includes organizations with competing priorities.

Such an inclusive governance model will also increase the value to be derived from the APCD. Broad stakeholder input and a fair decision-making process is essential to building a community data system that meets the diverse needs of the users. Stakeholder participation in decisions ranging from access to performance measures will assure that as many perspectives as possible are considered and that there is buy-in from the community.



In addition, an inclusive governance structure will:

- Allay stakeholder fears about loss of control. The technical challenges of a single data architecture are small when compared to the political challenges involved in sharing a common data infrastructure. Technological solutions exist that allow organizations to share data while also retaining control of their critical business functions. A structured approach to stakeholder management and outreach is critical for success.
- Allow for the alignment of hospital and physician incentives. There is a tremendous need to align hospital and physician incentives for performance improvement. A governance body for the APCD and related activities provides a mechanism for appropriate collaboration with other state-level quality initiatives, which will be necessary to formulating new evidence-based payment policies that support integrated and coordinated care for Massachusetts citizens.
- Meet the business objectives of all stakeholders. The goal for the future is to address the different business objectives using a common and flexible technical solution. The objective is not to implement a one-size-fits-all solution, but rather to understand the set of decisions each stakeholder makes with the data they collect and enable different decisions using the same measures.¹⁸

Most state all-payer claim databases have a governing board or advisory committee that administers or provides recommendations on the operation of, and the reports to be generated from, the databases.¹⁹ Massachusetts' statute specifically requires, among other things, that:

- (a) provider organizations which are representative of the target group for profiling shall be meaningfully involved in the development of all aspects of the profile methodology, including collection methods, formatting and methods and means for release and dissemination;
- (b) the entire methodology for collecting and analyzing the data shall be disclosed to all relevant provider organizations and to all providers under review.²⁰

There is no more efficient and effective way to comply with these requirements than through an inclusive partnership. The Data Release Committee established under the Massachusetts regulation (114.5 Code of Mass. Regs. 22:03) is a valuable step in assuring appropriate use of data, but more is necessary to achieve full partnership.

¹⁸ Booz Allen White Paper, *supra* note 18, at 12-13.

¹⁹ Nat'l Conf. of State Legislatures, *Collecting Health Data: All-Payer Claims Databases*, in *Health Cost Containment and Efficiencies Brief No. 4* (May 2010) [hereinafter NCSL, *Collecting Health Data*].

²⁰ M.G.L. ch. 118G § 6.

C. DATA AND SYSTEMS QUALITY

Data quality is essential to accurate measurement and publication of results, and the risks of errors are significant, from a misinformed public acting on inaccurate information, to the potential negative impact on provider reputation. It is critical to institute a robust and transparent set of data quality procedures, with roles and processes clearly understood and competently executed.

As the Division has learned in more than 20 years managing large databases and ensuring data integrity from the hospital discharge database to the claims database on behalf of the Massachusetts Healthcare Quality and Cost Council, transparent review processes are an essential ingredient. And, it should continue to employ experts in data and systems quality to ensure end-to-end management for accurate data.



D. MEASUREMENT VALIDITY, AGGREGATION, AND INTERPRETATION

It is important that any measurements used for policy, payment, and public consumption are well constructed and well presented to convey accurate, meaningful information. The National Quality Forum has done an excellent job at defining priorities, processes, and standards for measurement of quality and efficiency. The commonwealth should use NQF as a guiding resource for selecting valid, standard measures whenever the intention is to develop measures for policy and public consumption.²¹ The NQF provides benefits by conducting a transparent and scientific process for reviewing and approving measurements, and for publishing their findings to reflect the strengths and biases of various measures. The following list is an example of the types of attributes which are considered when assessing the validity of a measure:

- **Importance:** Measurements should capture an important attribute of quality, cost, and or patient experience; the measurement reflects a meaningful opportunity; there is variation in performance that can be managed and controlled to improve outcomes.
- **Well Designed:** Measurement specifications should be transparent, clear and accurately represent the concept being evaluated. Measures should be tested and found reliable in their ability to distinguish true differences in performance from measurement error. . Measurement methods should provide for appropriate risk stratification, risk adjustment, and other forms of recommended analyses. Appropriate statistical techniques should be applied to minimize the impact of outliers on average scores of performance.
- **Actionable:** Measurements should support decisions and change. Performance differences should be statistically meaningful, clinically and/or financially meaningful
- **Reflect Meaningful Attribution:** Measurements of performance should be summarized and presented at a provider level only when the provider has a significant opportunity to improve the quality of care and the resources used.
- **Ease of Interpretation:** Measures should be presented in a manner that simplifies interpretation, and minimizes the risk of false conclusions.

MHA will be a strong advocate to adopt a standard measurement validity framework for all applications of the APCD.

²¹ For example, Section 54 of Chapter 288 creates an advisory committee to the Department of Public Health to recommend a standard set of quality measures for public reporting.

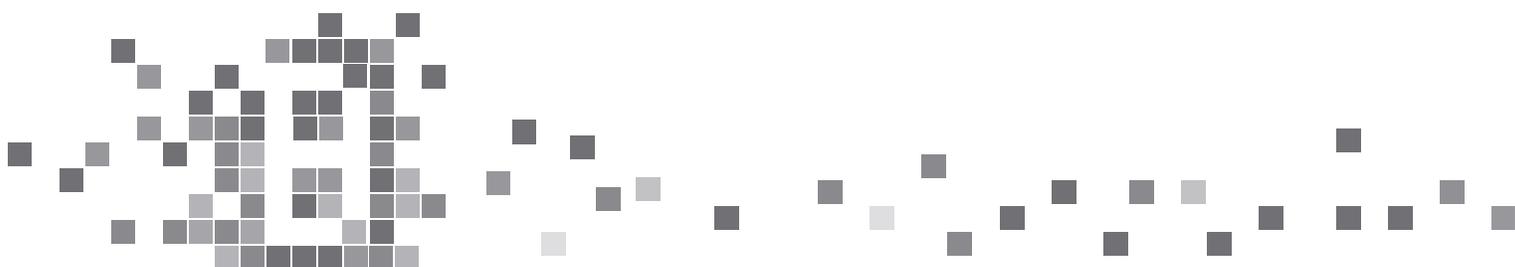
CONCLUSION

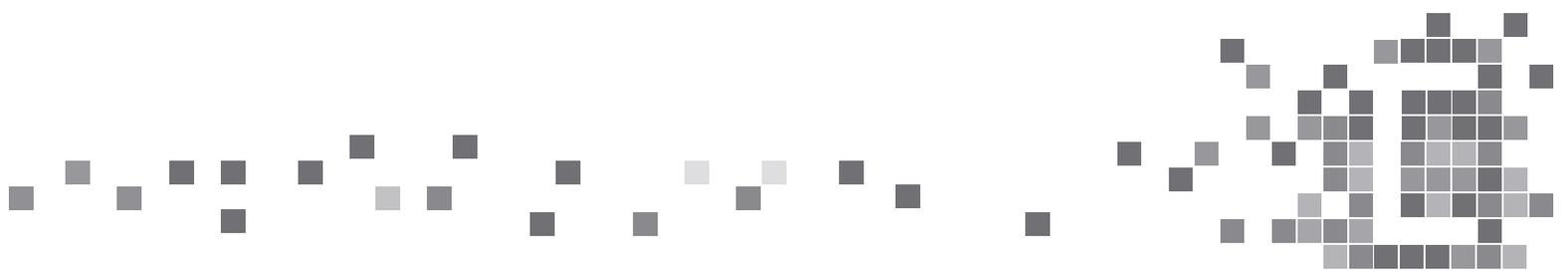
APCD data will complement existing data that hospitals already collect and use, and will contribute to a more complete view of performance and opportunity. The data will add significant value in the understanding of patient care, costs, and waste across a continuum of settings; in developing tactics and strategies that bring value to a range of stakeholders in healthcare affordability; and in improving providers' ability to contribute to total healthcare cost management while sustaining a thriving enterprise.

Providers can translate APCD data into a valuable asset for managing their performance. The added value of the data and the more robust tools they support will enable refinements in payment and delivery reforms over time that should yield significant positive results.

MHA and hospitals look forward to working with the Division on the implementation and ongoing operations of the APCD to achieve the goals the Legislature set out, as well as the goals MHA has articulated in this paper. With proper governance and data access, strategies and alignment for improving healthcare costs can initiate from private enterprise and consumers, as well as from policy and research. The APCD is a fundamental – and very significant – step forward.

The Division of Health Care Finance and Policy in its implementation and operation of the APCD must recognize various stakeholders' differing needs and uses of the data and information/reports from the database. While the Division has legal authority to collect data for the APCD and access to the data is governed by applicable statutory privacy and confidentiality provisions, it is essential that the agency continue engaging with external stakeholders to inform its processes and decisions. Pending enactment of statutory changes referenced above, the Division should adopt an open and inclusive public-private partnership with a consensus-based process for setting the scope and priorities for the ongoing administration of the Massachusetts APCD.





MHA MASSACHUSETTS HOSPITAL ASSOCIATION

75th
Anniversary

The leading voice of hospitals since 1936.

5 New England Executive Park
Burlington, MA 01803-5096
www.mhalink.org

OCTOBER 2011

