

# Issue Brief

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## National All-Payer Claims Database Conference Overview

April 17 – 18, 2008

Beverly, Massachusetts

The objectives for the conference were to offer an opportunity for the states to have an interactive dialogue on the subject of establishing all-payer claims databases, to begin to harmonize the various state efforts, and to enable the states in the planning phase to return with an understanding of applications and uses so that they can make a business case to the decision-makers in their state.

The sources of claims databases are carriers, plans, third-party administrators (TPAs), pharmacy benefit managers, state Medicaid agencies, and Medicare. They contain eligibility and claims data (medical, pharmacy, and dental), and are being used to report cost, utilization, and quality information.

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## Background

The Massachusetts Health Data Consortium, the National Association of Health Data Organizations (NAHDO), the Regional All Payer Healthcare Information Council (RAPHIC), and the New Hampshire Institute for Health Policy and Practice at the University of New Hampshire (NHIHPP) partnered to hold the first National All-Payer Claims Database Conference.\* The meeting was held at the Richard E Wylie Conference Center in Beverly, MA on April 17-18, 2008 and attracted 125 people representing 25 states and the District of Columbia. The participants included staff members from state agencies, health data organizations, vendors, providers, other non-profit organizations, academics, health plans, and employers/purchasers.

The agenda included five sessions designed to introduce the participants to the value of an all-payer claims database, share lessons learned and best practices from early implementing states, discuss the availability of Medicare and Medicaid data with a representative from the Centers for Medicare & Medicaid Services (CMS), address efforts to harmonize the collection and release of data via both presentations and breakout discussions, and to

explore the possibility and benefits of building a multi-state database. In addition, the participants heard a keynote presentation from the Deputy Director of the Agency for Healthcare Research and Quality (AHRQ).

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## Applications

Four presentations from representatives of Maine and New Hampshire highlighted some of the important applications of using all-payer claims data.

The New Hampshire Department of Health and Human Services has issued a series of reports using the all-payer data, including the first state study comparing children's health for S-CHIP and commercial insurance regarding access, prevention, care management, utilization, and payments in the state. Upcoming studies will address prevalence and cost for cardiovascular disease, diabetes, chronic respiratory disease, and mental health. The NH Comprehensive Health Information System ([www.nhchis.org](http://www.nhchis.org)) Website contains both the aforementioned studies, and an interactive Web

query tool that produces eligibility and claims reports on Medicaid and commercial datasets.

The New Hampshire Insurance Department has established the NH HealthCost Website ([www.nhhealthcost.org](http://www.nhhealthcost.org)). This site is designed to enable consumers to make more informed decisions about where to seek care and what it will cost them, depending on which insurance plan they have and which provider they seek for treatment.

The Maine Quality Forum is disseminating research on quality, evidence-based medicine, patient safety, and technology assessment, as well as providing recommendations regarding the State Health Plan. The presentation included a model of how data can be used to effect change, when research informs consensus guidelines, which in turn can establish performance indicators for provider quality.

The University of New Hampshire presented findings from population-based research. Geo-linking of claims data to other population-based data sources, such as census data, enables analyses of the impact on public health of factors such as pollution, climate change, socio-economic status, transportation access, and obesity.

Issues to be addressed:

1. Provider identification. Even the implementation of the national provider identification system will not resolve all the problems with assigning each patient to the appropriate provider. States are spending significant resources to update and maintain uniform provider databases spanning multiple insurance carriers who submit all-payer data.
2. The uninsured. They are typically not included in claims databases, although there is a desire to develop uniform methodologies for cost-effective collection of this population's data.
3. Value proposition. States that are not collecting claim data will need help articulating and communicating the value proposition to garner support from their stakeholders

## Case Studies

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Four states that have established all-payer claims databases discussed their lessons learned and shared best practices. The moderator asked the speakers to give a history of each state's efforts, and to address financing, the legal framework, and convincing policymakers and stakeholders to go forward with implementation.

**Vermont** is in the midst of implementing an all-payer database as charged by a 2006 legislative mandate. Start-up costs are expected to approximate \$500,000 for state fiscal year 2009 including an outsource contract for data collection and initial reporting. Policy makers were convinced of an all-payer database's value because of the limitations of hospital discharge data to comprehensively inform access, cost containment, consumer and purchaser reporting, and quality efforts. The rule-making process is underway and adoption of the final rule is anticipated in July 2008.

Legislation was passed in **Utah** in 2008 to fund the all-payer database, with an expected start date of

July 1, 2008. Utah's Health Data Committee stakeholders are described as the "five P's": purchasers/business, providers, public policy, patients/consumers, and payers and health systems. Annual costs are projected to be \$1 million, primarily from state and Medicaid matching funds. The Health Data Authority Act of 1990 gives the state authority over insurance plans. Stakeholders such as the Legislature, the Chartered Value Exchange, the Department of Insurance, public health programs, and private advocacy groups have been supportive and cooperative partners.

**Maine** has one of the oldest all-payer databases in the nation. The Maine Health Data Organization was established in 1996, and in 2001 legislation enabled the collection of data directly from carriers and TPAs,<sup>1</sup> with the rules finalized in 2002 (they have been modified three times since then). Data submission began in January 2003 and the first release was April 2005. The budget approximates \$1.8 million with nine FTEs, and revenue is from a surcharge to providers and payers, along with some

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<sup>1</sup> A federal court ruling on March 24, 2004 determined that claims data held by TPAs are not plan assets, and therefore must be provided to the Maine Health Data Organization.

database sales. It was recommended to obtain input from the data submitters prior to formal rule-making, to strive for consistency with national standards, and to assure safe data storage and release.

The **New Hampshire** presentation keyed in on two primary questions for states to address: (1) Do you want the data? and (2) How do you make it work? The Department of Insurance initiated the process because premiums were rising quickly, and there was no data to answer the Legislature's questions as to why this was so. They created a "virtual health data agency," primarily with Medicaid funding. There is a partnership between the Insurance Department and the Department of Health and Human Services. In addition, an external contract is in place for data management and a Web-based query tool. New Hampshire indicated the importance of stakeholder involvement early in the process. It took six months to draft the rules, but they have worked well. The most critical key to success is to show people how the database will be useful – it's an expensive and time-consuming program to establish. The NH HealthCost Website was created to demonstrate the database's value, and the Legislature is satisfied with the data reports it has been receiving.

During Maine's presentation, these fundamental principles were highlighted as challenges for the states:

1. No one wants to pay for the cost of creating and managing a database.
2. No one wants to provide their data.
3. Everyone wants the aggregated data that results from the database.

## Value to Researchers

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The keynote presentation was by Kathleen Kendrick, Deputy Director of AHRQ. She said that value is not the product of regulation, but rather it is the product of informed choice – we need to change the culture to achieve this transformation. This change should be a shared endeavor between the federal, state, and private sectors with rewards for change. One aspect that is necessary is transparency: everyone sees everything; i.e., what the data are, where the information comes from, and how results are calculated. Data are necessary but not sufficient: we need a system that yields usable information and

supports good choices for patients and the healthcare system, and we need to build such a system.

In order to bring quality improvement in line with cost increases, we need: a delivery system design that goes beyond hospitals, real-time information, evidence-based management, and policy adjustments for improvement. Quality of care does get better when we start to look at it, but beware of measurement fatigue.

A request from AHRQ to the states and others in the audience: Work together to get to where we deliver the right care for the right patient at the right time. Create all-payer claims databases, and we can help, and you can help each other.

## Integrating Public and Private Sector Databases

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Medicare has a wide range of data of interest to states and researchers, including claims, Part D prescription drug, enrollment, provider files, assessment data, survey data, chronic conditions, and Medicaid data. CMS is understandably concerned with protecting this data, and this session addressed how states can obtain Medicare data while ensuring beneficiary security and privacy.

Bill Saunders, Deputy Chief Information Officer of CMS, described some of the challenges of working with claims data: the files are large and cumbersome, file documentation may be complicated or obscure, date field structures may be formatted differently, and users need to spend considerable time familiarizing themselves with the data and documentation. In addition, there are several linking and analytic issues to be addressed.

CMS has limited authority to release person-level data, but several states have successfully requested and obtained Medicare claims data. If approved, a request for one state to cover extracting and encrypting costs would approximate \$30,000 - \$40,000 per year. Requests should be submitted to the Research Data Assistance Center, [www.resdac.umn.edu](http://www.resdac.umn.edu), and need to include a data use agreement. Such requests may take several months to process. Another consideration is the Privacy Act

protection which restricts the release of the individual-level physician identifier.<sup>2</sup>

Al Prysunka, Executive Director of the Maine Health Data Organization, described his organization's experience trying to obtain Medicare data. Complicating matters for accessing CMS data is that Medicare and Medicaid have different legal restrictions. Another issue was that, once obtained, the Medicare data did not match the commercial X12N formats, and the MHDO had to develop a mapping methodology to align the Medicare and commercial data (this mapping methodology can be made available to other states). The costs for Medicare data to MHDO were just under \$15,000 a year, and \$74,000 over five years. While the process that Maine went through was difficult and took three years, Al's message was "If we can do it, you can do it."

## Harmonizing Collection and Release

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The panelists discussed ways to harmonize the collection and release of data, including the perspective of a health plan. Breakout sessions then addressed these topics, along with national standardization.<sup>3</sup>

Vermont explained why harmonizing rules for data collection is important: there are many cross-border issues such as employers, employees and residents who cross state lines related to health insurance plans and healthcare providers; the potential to develop a regional population-based data analysis capability; increased efficiency and reduced cost for insurers; and improved data quality due to common standards.

Massachusetts created the Health Care Quality and Cost Council as part of its 2006 health care reform law, and the Council decided to create an all-payer database. While the state supports the concepts of standardization and harmonization, the presentation frankly stated that the priority is to focus on the needs of the state first, and only then to move onto regional/national harmonization. One aspect of harmonization that is appealing is the ability to copy other states' regulations. Massachusetts also uses the

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<sup>2</sup> The group tax identifier is not protected, but the tax number varies in consistency and quality.

<sup>3</sup> The breakout session results will be detailed in a subsequent meeting report.

Maine Health Information Center as a contractor, which facilitates harmonization/standardization across Maine, Massachusetts, New Hampshire, and Vermont. The data disclosure rules, which were released for public comment on April 16<sup>th</sup>, are modeled on those of Maine and New Hampshire.

Harvard Pilgrim Health Care of New England offered a payer perspective. Payers absolutely believe in harmonization, because pulling the required data is enormously labor-intensive and common approaches are more efficient. In addition, some plans feel threatened by all-payer databases because of concerns for patient privacy and the potential to release provider contract terms. Plans should be part of the data collection and release rule-making process from the beginning, because they have a detailed understanding of claims data and can make useful suggestions to accomplish policymakers' goals.

Challenges to harmonization:

1. Populations covered. States have different definitions for the populations in their database (e.g., all residents vs. all who use the state's healthcare services), as well as the services included and specific data fields required.
2. Data element definition. The differences in data elements are often due to variations in legislative and political environments.

## Towards a Multi-State Database

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The final session addressed developing a multi-state all-payer claims database and the benefits of such a resource. The key components of such a database would be ICD-9 diagnosis codes, CPT/HCPC/ICD/revenue procedure codes, patient identifiers, and provider information.

The Maine Health Information Center has already begun to conduct multi-state research projects in Maine and New Hampshire. Three studies are underway: healthcare utilization, payment, and quality profiles by geographic area; comparative health metrics for similar employers in Maine and New Hampshire; and comparative payments for outpatient surgery in the two states.

The Muskie School at the University of Southern Maine and the Harvard School of Public Health recently

received funding from the Robert Wood Johnson Foundation to study the affordability of state coverage plans in Maine, Massachusetts, and Vermont. Multi-state data will enable the researchers to answer questions regarding enrollment rates, and how cost-sharing affects utilization by income level and health status.

A representative of the Dartmouth Atlas of Health Care Project was scheduled but unable to attend due to an urgent situation. His presentation asserted that multi-state databases would be the next generation of health services research, enabling studies for the first time of the under-65 population across states. Dartmouth would like to have the ability to track a cohort from birth to death, linking vital statistics data to the all-payer databases.

Challenges to building a multi-state database:

1. ICD-9, CPT, and HCPC codes vary locally, even with standardization under HIPAA.
2. ICD-9 and revenue codes are reported inconsistently.
3. Patient identifiers are protected by varying encryption algorithms, and some states prohibit release of patient identifiers.
4. Lack of a unique provider identifier.
5. Variability in data release rules.
6. Size of the database – a combined ME/MA/NH dataset would be 140 million claim lines per year.

## Next Steps

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- Follow-up national meetings on the topic of all-payer claims databases are being planned. The next opportunity is likely to be the next NAHDO conference on October 26-28, 2008 in San Antonio. [www.nahdo.org](http://www.nahdo.org)
- RAPHIC will update its Website to include resources for states that are implementing or considering implementing all-payer claims databases. In addition, all interested states are welcome to join RAPHIC. RAPHIC conducts

monthly conference calls, and several speakers expressed appreciation for the sharing of information and expertise that RAPHIC members provide. [www.raphic.org](http://www.raphic.org)

- The Commonwealth Fund will post an e-Forum of the Powerpoint presentations and audio of the speakers' remarks on its Website. The MHDC ([www.mahealthdata.org](http://www.mahealthdata.org)), NAHDO, and RAPHIC Websites will have links to the e-Forum. [www.cmf.org](http://www.cmf.org)
- A detailed written meeting report of the conference proceedings will be issued this summer. It will be available on The Commonwealth Fund Website and the Websites of the partnering organizations.
- An article based on the issues raised at the conference will be submitted to a peer-reviewed academic journal for publication in fall 2008.
- A state "user group" will be formed to work together to standardize state data requests for Medicare and Medicaid data, to reduce the burden on both states and CMS.

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