



**Connecticut State Medical Society
Connecticut Chapter of the American College of Physicians
Connecticut Chapter of the American College of Surgeons
Testimony on House Bill 5038 an Act Implementing the Governor's Budget
Recommendations Concerning an All-Payer Claims Database Program.**

**Public Health Committee
March 7, 2012**

Senator Gerratana, Representative Ritter and members of the Public Health Committee on behalf of the more than 8,500 physicians and physicians in training of the Connecticut State Medical Society (CSMS) and the Connecticut Chapters of the American College of Surgeons and the American College of Physicians, thank you for the opportunity to present this testimony to you today on **House Bill 5038 An Act Implementing the Governor's Budget Recommendations Concerning An All-Payer Claims Database Program.**

In an effort to increase transparency in the health care system, lower the cost of health care, and study health care trends and population health, states such as Connecticut are mandating the creation of all payer claims databases (APCDs). APCDs typically include data derived from medical, pharmacy, and dental claims from private and public payers. Currently 14 states either have or are implementing an APCD. APCDs are potentially valuable sources of data for policy-makers, physicians, patients, payers, and purchasers of health care if the claims data is accurate and reported in a usable format. CSMS strongly supports the development of APCDs as an educational and informational tool and resource for physicians, insurers, policy-makers and patients, if constructed in a way that provides valid, reliable and relevant data in a transparent manner. But as it is currently written, CSMS must oppose HB 5038, [BILL TITLE]

Aggregated, accurate health care claims data has the potential to provide useful information concerning health care service resource utilization. That is because claims data contains information concerning: the specific services that patients receive; patient diagnoses; the payer who paid for the services, the health care professional who provided those services; the particular procedures performed; the treatments obtained; and the service setting, including the specific facility where the services were provided. This data also has the potential to enable state policy-makers to help foster key improvements in the state's health care delivery and financing system by identifying where health care resource utilization varies in key populations, identifying trends in population health, identifying potential targets for public health interventions and by supporting the efforts of physicians and other health care providers to improve the health care services they provide by giving them access to this data.

Aggregated, accurate health care claims data also allows researchers to identify health care claim trends and variations that warrant further analysis and investigation. However there are limits to what this data can show. State and national clinical registries provide valuable clinical and outcomes data. Researchers should supplement health care claims data with this additional information as it becomes available, and in **no** event should claims data alone be used to reach conclusions which require consideration of outcomes and other clinical

information, such as determining the efficiency of specific treatments or the specific public health interventions to be undertaken.

Accurate, comparative health care claims data support physicians' efforts to design targeted quality improvement initiatives and to compare their own performance with that of their peers.

However, inaccurate health care claims data used for these purposes can be harmful, and an APCD that fails to meet the accuracy, transparency, due process and external validation and oversight requirements creates an unreasonable risk of patient confusion and deception, unjustified and injurious disruption of patient-physician relationships, and unfair disparagement of qualified physicians' reputations. HB 5038 should require APCDs to provide physicians with full access to the underlying claims data, including an opportunity and process to correct errors and to submit additional information for consideration.

In addition, CSMS believes that it is imperative that the proposed All Payer Claims Database (APCD) in this state ensures all the following:

(1) that physicians, physician organizations, providers, health care purchasers, and state policy-makers receive reliable, valid, meaningful, and accurate information when making important health care decisions;

(2) that any programs that evaluate the performance of physicians use accurate, meaningful, and statistically valid measures, methodologies and data, and that those measures, methodologies, and data and any limitations associated with those measures, methodologies, and data are completely transparent and fully disclosed to physicians and the general public; and

(3) that clear standards of statistical significance using confidence levels and sample size requirements be developed before any data is reported on by insurer, provider or provider group and that the sample size and confidence level reporting be at the quality measure level;

(4) that physicians have the right to review, and correct any errors in, performance evaluations or the data upon which those evaluations are based;

(5) that participation is voluntary and parties "may" deposit their data, as opposed to requiring it through the use of "shall."

(6) that if the data is to be used for the purposes of quality improvement and consumer decision-making, that providers and consumers not be charged a fee to access information;

(7) that a separate non-profit entity be formed to establish the APCD and that entity have no financial or other ties to existing for-profit health insurers;

(8) that patient information is protected and safeguarded and that patients, employers, and health-care providers be protected by all necessary means, including deletion of patient identifiers.

APCDs and Physician Profiling

Nearly every major health insurer sponsors a physician profiling program to drive pay-for-performance, tiered network, narrow network and/or public reporting systems. If these profiling programs are to be of any value in helping physicians improve their performance, each physician and physician group which has been profiled must also receive the detailed data upon which the profile score has been based, as well as appropriate benchmarking data against which the profile score can be compared. The reports health insurers currently provide to

physicians are often not helpful to physicians due to several limitations in the way insurers report the profiling data. Unfortunately, HB 5038 does not make significant progress in improving the utility and transparency of physician-profiling activities because it does not require health insurers that access the claims data to follow consistent standards for reporting physician data. CSMS believes that there should be mandated physician reporting standards, including guidelines for quality reporting, resource use reporting, transparency, and reconsideration requests. These would increase the uniformity and depth of data of insurers' and others reports and boost the value and utility of the data to physicians.

Measuring physicians' performance based on quality and cost efficiency is a relatively new, complex and rapidly evolving area. To ensure that consumers receive reliable, valid, meaningful and accurate information when making important health care decisions, it is critical that physician-profiling programs use accurate, meaningful, and statistically valid measures, methodologies and data.

Because those using physician-profiling programs may have a financial interest in steering patients away from high-quality physicians and toward physicians with lower costs of care or reducing the size of the physician network to limit access to care, the profit motive may affect rankings in such programs. This is a potential conflict of interest requiring disclosure, scrutiny and oversight. The independence, integrity and verifiable nature of the profiling process are paramount.

Physicians who practice as an organized group ("medical group") regularly employ inter-specialty cooperation and team-based care to coordinate medical services for patients. Therefore it is administratively infeasible to segregate individual physician performance from that of the group as a whole. It would be misleading to the public to provide such individual physician data. No physician-profiling program should publicly disclose, or otherwise use for any network or reimbursement purpose, the ranking of individual physician members of a medical group that is subjected to a physician-profiling system. All physicians in a group practice should receive the same ranking as that of the group as a whole, to be identified as such.

Profiling systems which fail to meet the accuracy, transparency, due process and external validation and oversight requirements established by this legislation create an unreasonable risk of patient confusion and deception, unjustified and injurious disruption of the patient-physician relationship, and unfair disparagement of qualified physicians' reputations.

Though CSMS strongly supports the concept of the development of a well-constructed and well-maintained APCD in Connecticut. We would urge the committee to look closely at APCD legislation in Wisconsin, which we believe has built in most of the necessary safeguards that would make Connecticut's proposed legislation stronger. However, presently CSMS cannot support HB 5038 as presented because it fails to provide the necessary patient and physician protections and certainties of uniformity of data collection, tabulation, storage, analysis and reporting that would be necessary for such data to be used to make informed decisions about the health and safety of patient medical care in Connecticut.