

Rhode Island Health Care Cost Trends Steering Committee

EIGHTH MEETING, JANUARY 14, 2019



Agenda

1. Welcome
2. Compact Signing and Executive Order Update
3. Data Analysis Update
4. Scope of Work for the Next Six Months
5. Discussion of Data Use Strategy Recommendations
6. Break
7. Discussion of Data Use Strategy Recommendations
8. Public Comment
9. Next Steps and Wrap-Up

Compact Signing and Executive Order Update

Data Analysis Update

Refresher: analytic plan (discussed at meetings #1 and #2)

Goal: to analyze RI all-payer claims database (APCD) to identify cost trends and select drivers of cost:

- Aim #1: To assess cost trends in RI
- Aim #2: To assess select cost drivers in RI
- Aim #3: To further deconstruct cost by volume and price
- Additional data request sent to all carriers to:
 - Assess the significance of missing self-insured and non-claims data
 - Validate our data against summary reports from carriers

Data sources

- RI All-Payer Claims Data (APCD) (2014-2017*)
- For patient attribution to PCPs: APCD (utilization-based)
- For PCP attribution to provider groups: have received provider directories from OHIC, BCBSRI and Coastal Medical

What is in the APCD?

Typical Claims-Based Costs

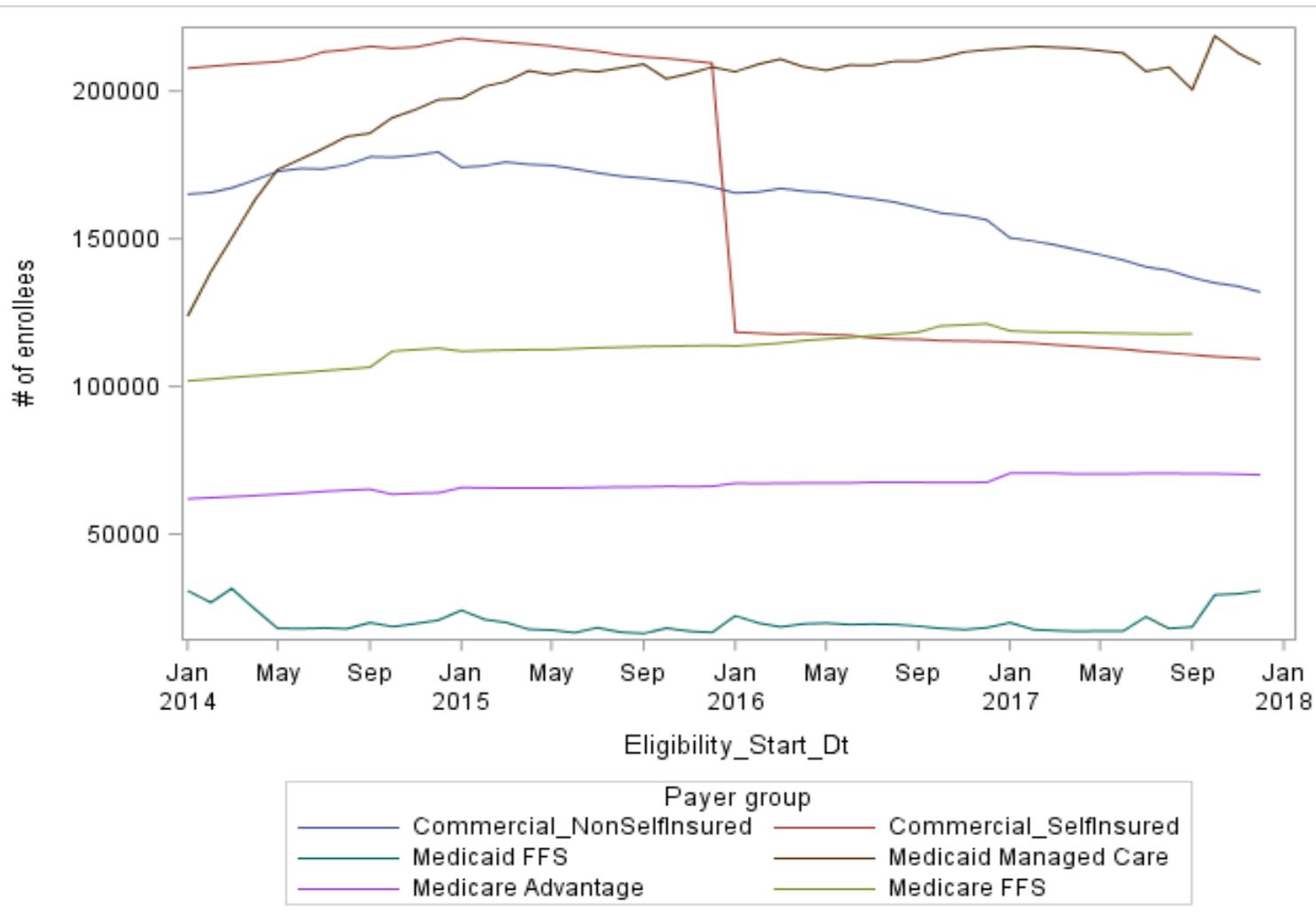
- Hospital inpatient
- Hospital outpatient
- Physicians
- Other professionals
- Home health and community health
- Long-term care
- Dental
- Pharmacy
- Durable medical equipment
- Hospice

What claims-based costs cannot measure: administrative costs, lump sum or other non-claims-based payments to providers

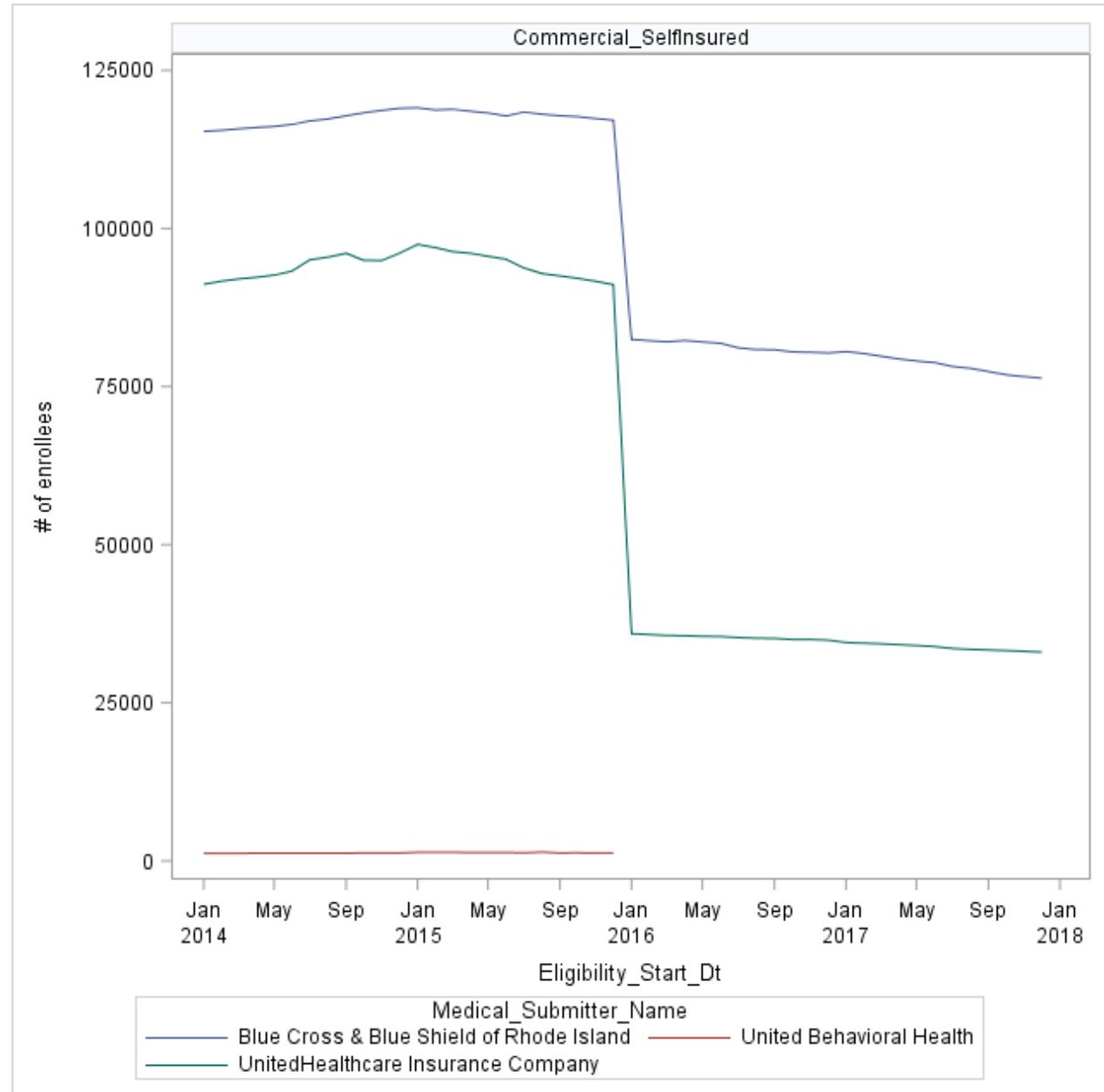
Analysis to date

APCD Counts, All Payers

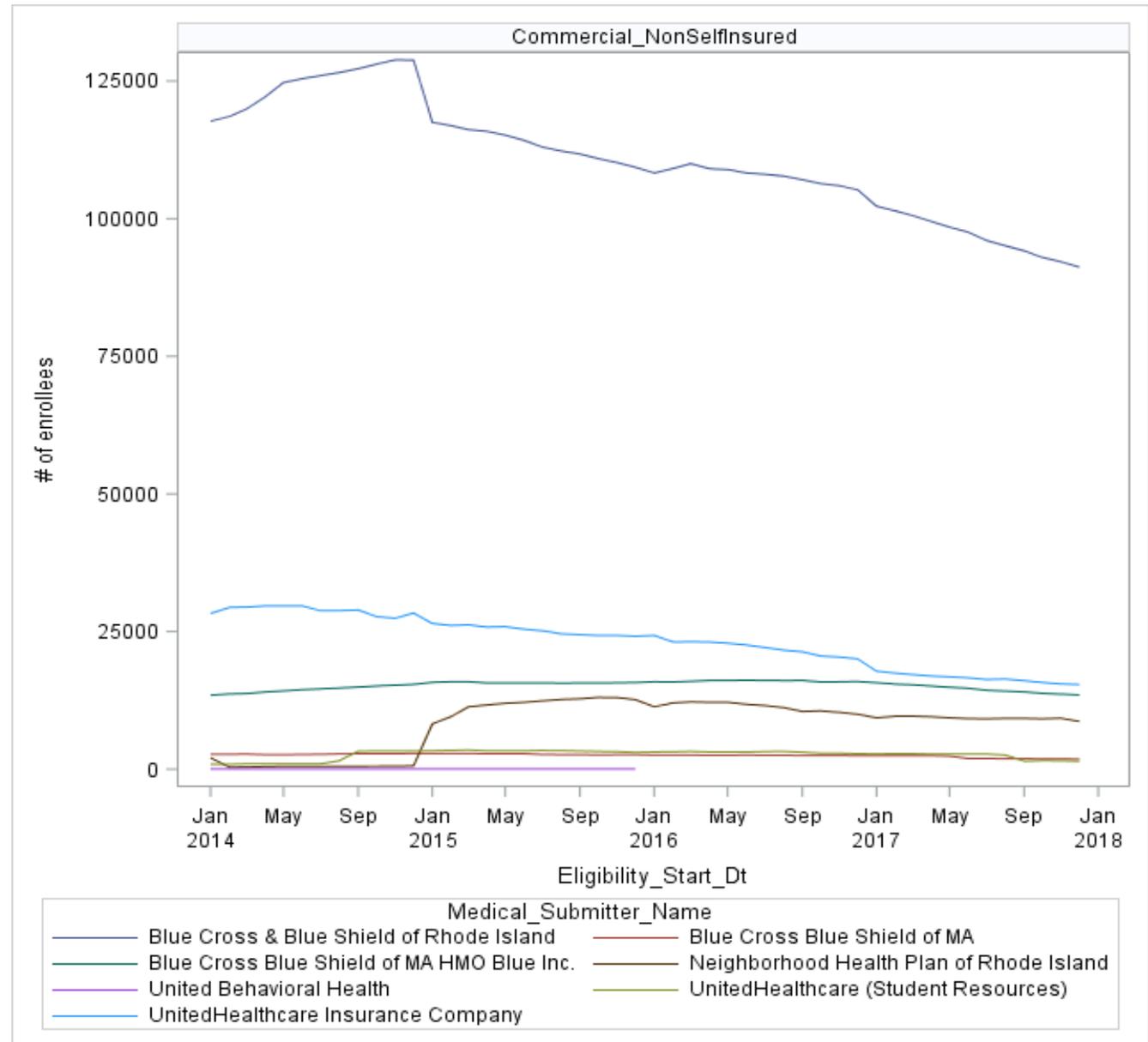
Number of enrollees with at least one claim in any given month



APCD Counts, Commercial Self- insured

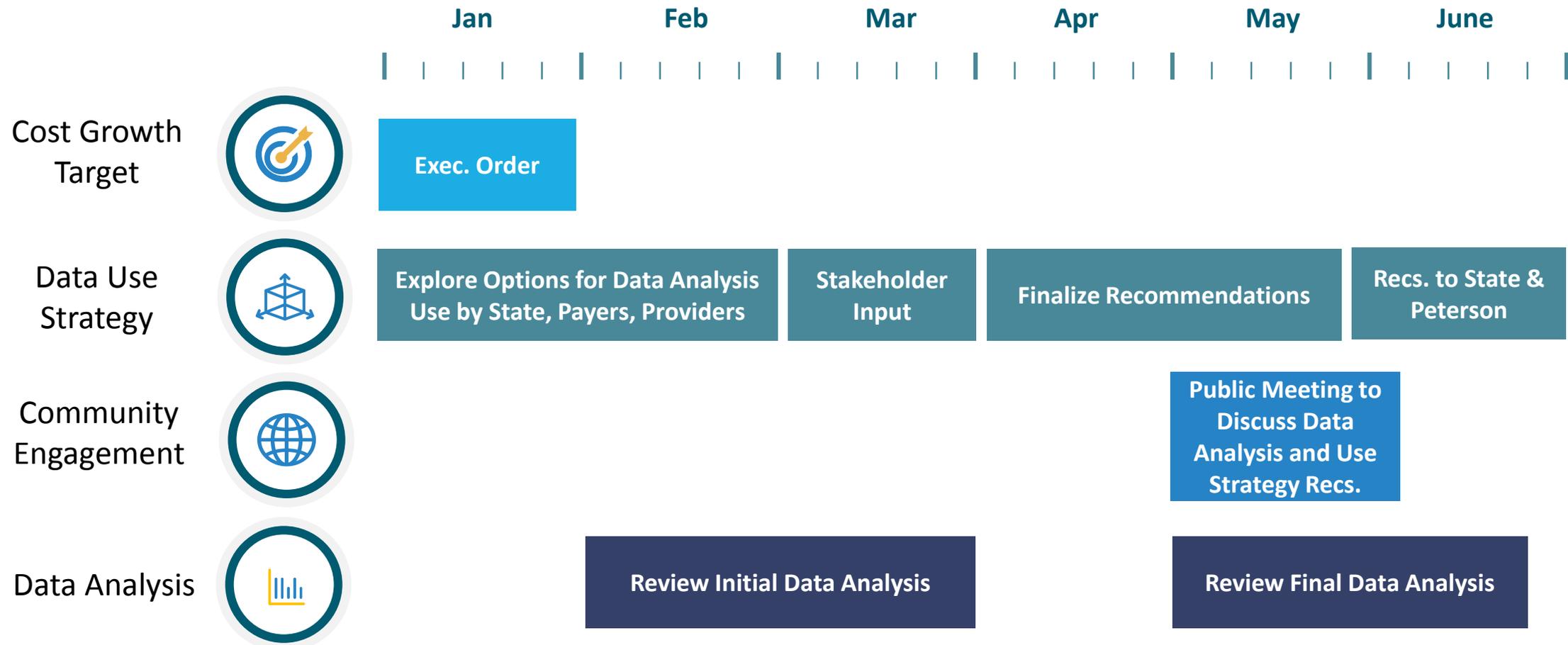


APCD Counts, Commercial Fully-insured



Scope of Work for the Next Six Months

Cost Trends Project Timeline for 2019



Data Use Strategy Recommendations

- Up to this point, the Steering Committee has focused on developing a cost growth target. Moving forward, we will focus on data use strategy recommendations, informed by other states' practices, Brown's data analysis and stakeholder input.
- As a reminder, in June we will deliver a recommended sustainable Rhode Island data use strategy to the State and the Peterson Center, one that could also serve as a model for other states.
- The final report should provide:
 - recommendations to leverage state data analysis in the future
 - Brown's analytic methodology, barriers encountered, and solutions from Brown to the State to allow the State to internalize and build on the learnings

Discussion of Data Use Strategy Recommendations

Goal for today's discussion

- Begin to develop recommendations to the State regarding ongoing use of the all-payer claims database (APCD) to support efforts to reduce health care cost growth in RI
- Our focus: how can we provide better information to support the decision-making of those who influence health care costs (i.e., drive them toward higher-value – a higher ratio of quality to cost)?
- We will revisit this issue in February, and release recommendations for public comment in March

Part 1: Refresher: What have other states/organizations done with cost and quality data?

DISCUSSION OF DATA USE STRATEGY RECOMMENDATIONS

Types of uses of APCDs

1. To support regulatory activities and policy initiatives
2. To facilitate price and quality transparency for consumers and policymakers
3. To support regional or provider-level delivery system improvement

Use cases from the November conference: regulatory/policy

- **New Hampshire:**

- Carrier discount study
- Network adequacy assessments
- Mental health parity compliance analysis
- Analysis of potential insurance mandates

- **Oregon:**

- Analysis of primary care spending
- Analysis of surprise billing to support development of regulations

Use cases from the November conference: transparency

- **New Hampshire:**

- Consumer-facing website

- **Washington Health Alliance:**

- Public reports aimed at consumers, providers and payers (esp. self-insured employers)
- Community Checkup Reports (variation analyses by geography and by medical groups)
- Medical group rankings on quality measures
- Analyses of potentially avoidable/wasteful care
- Analyses of spending trends analysis
- Analyses of variation in pricing

- **Massachusetts:**

- Consumer-facing website
- Variation analyses/reports similar to Washington

Use cases from the November conference: quality improvement

- **Washington Health Alliance:**

- “First, Do No Harm” (education based on Choosing Wisely campaign)
- Variation analysis related to low-value care
- Coupled with specific, provider-focused efforts to reduce unnecessary tests, treatments and procedures

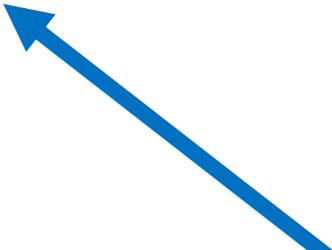
- **Vermont:**

- Community health profiles by region
- Practice profiles
- Linked with practice-level, regional and statewide ACO quality improvement efforts

Part 2: One framework for your recommendations: who/what are we trying to influence to affect health care cost growth?

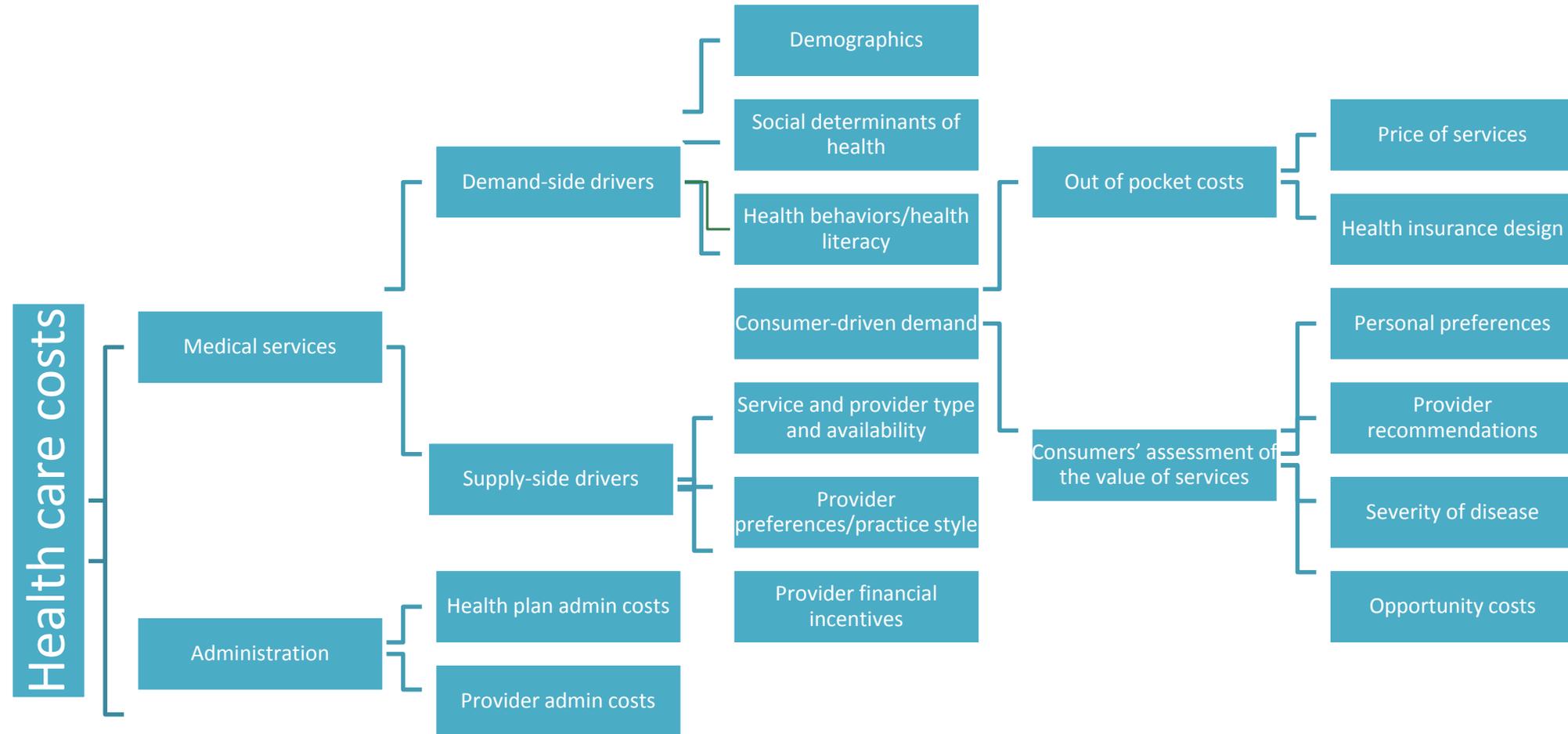
DISCUSSION OF DATA USE STRATEGY RECOMMENDATIONS

Cost = Price X Utilization

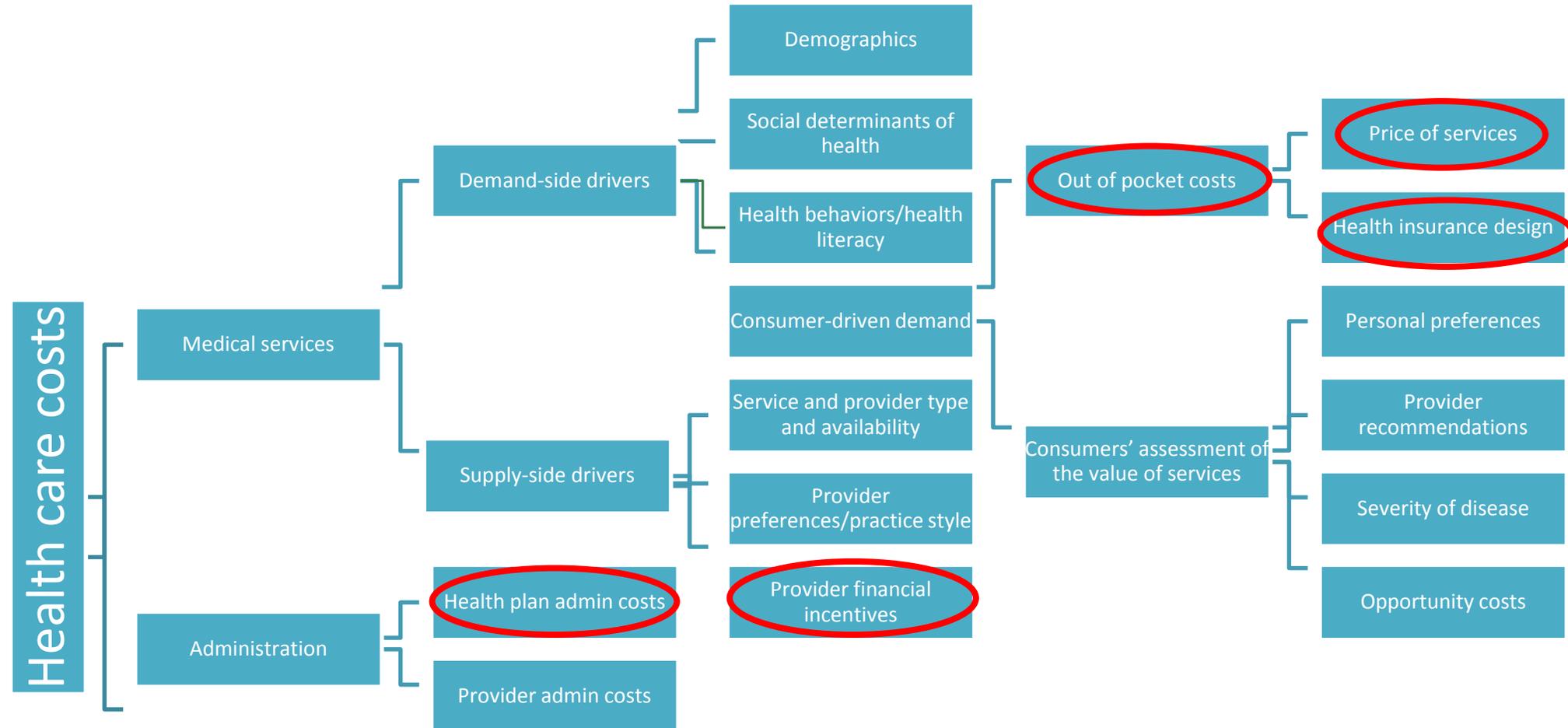


Historical efforts to reduce cost growth have focused *mostly* on price (price paid to providers, price to consumers at point of service)

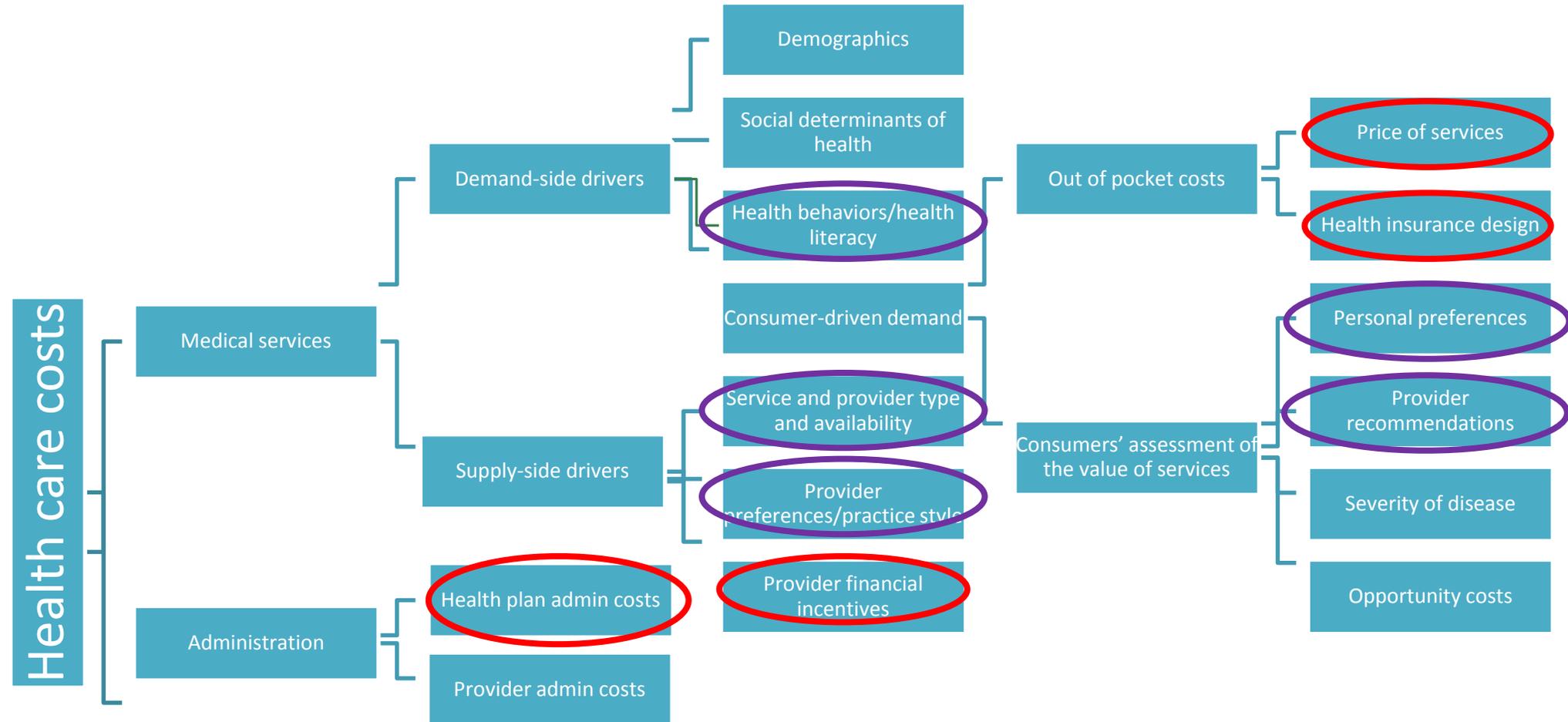
But so many other factors drive health care costs...



Where do we tend to focus to influence those factors?



Where could we intervene with data for greater impact?



Part 3: Another way of framing it:
Who do we want to influence and
what data/analysis will best serve
that purpose?

DISCUSSION OF DATA USE STRATEGY RECOMMENDATIONS

Whose decisions/behavior do we want to change through the use of data?

- Consumers?
- Payers?
- Providers?
- Regulators/policy-makers?
- NOTE: these options are not mutually exclusive

Consumers: how could APCD data help?

- More informed choice of providers
- More informed choice of services (e.g., Choosing Wisely, shared decision-making)
- Better understanding of overall prices
- Better understanding of out-of-pocket costs
- NOTE: The literature suggests that consumer-facing transparency efforts have had very limited effects on consumer choice and cost*

*See, for example, Zhang, 2018; Desai, 2017; Semigran, 2017; Mehrotra, 2017; Gourevitch, 2017

Payers: how could APCD data help?

- Better identification of high quality/low cost providers (variation analysis) to support:
 - More informed contracting decisions
 - More informed plan design decisions
 - More informed payment policy
 - More informed network design
- NOTE: most payers already use their own data for these purposes

Providers: how could APCD data help?

- Better information on cost and quality to support:
 - Referrals/contracting strategies/choice of site of service
 - Advice to patients
 - Reductions in the use of unnecessary or harmful services
 - Substitution of lower cost and/or higher quality providers
 - Benchmarking against colleagues in RI and/or elsewhere
 - Care transformation?
- NOTE: there is little evidence in the literature regarding whether provider-oriented transparency efforts change practices or reduce cost growth

Regulators/policy-makers: how could APCD data help?

- Better information to support:
 - Rate reg
 - Medicaid
 - Laws or regulation related to consumer, provider or payer behavior
 - Examples:
 - Limitations on insurance design
 - Limitations on provider contracting
 - Requirements regarding provider payment
 - Supply decisions (e.g., certificates of need)
 - Examination of network adequacy
 - Examination of provider payment differentials

Part 4: Discussion: Rhode Island Recommendations

DISCUSSION OF DATA USE STRATEGY RECOMMENDATIONS

Discussion Questions

- What kind of reporting from the APCD is likely to have the greatest impact on reducing health care cost growth?
- What is *your* highest priority for reporting from the APCD, and why?

Next Steps

- Further discussion at the next meeting
- Assess the feasibility of preliminary recommendations for analysis and reporting
- Reach out to potential users of the data for input on what would be most useful

Public Comment Period

Wrap-Up and Next Meetings

All meetings are Mondays from 9:00 a.m.-12:00 p.m.

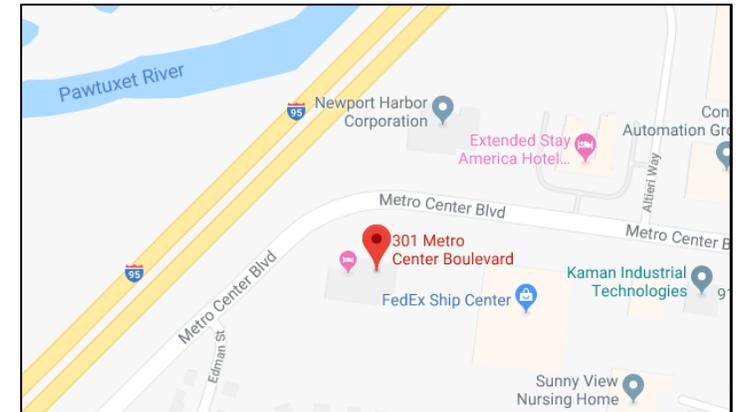
February 11 301 Metro Center Blvd, Suite 203, Warwick, RI 02886

March 11 301 Metro Center Blvd, Suite 203, Warwick, RI 02886

April 8 301 Metro Center Blvd, Suite 203, Warwick, RI 02886

May 13 301 Metro Center Blvd, Suite 203, Warwick, RI 02886

June 10 301 Metro Center Blvd, Suite 203, Warwick, RI 02886



Appendix

ADDITIONAL DETAIL ON THE ANALYTIC PLAN

Aim 1 Analytic Approach: Cost Trends

- Calculated as mean annual risk-adjusted medical expenditures per person per year
- For each year, we will report:
 - Mean annual medical expenditures per person
 - Median expenditures per person
 - Expenditures by quintile
 - Total member enrollment
- Will also report year-to-year statistical trends



Stratified by payer (e.g., commercial, Medicaid MC, Medicaid FFS, Medicare Advantage, Medicaid FFS, dual eligible)

Aim 2 Analytic Approach: Cost Drivers

- All decomposition analyses to be stratified by payer type, health plan, and provider group. Prioritize 2-4 measures.

Annual expenditures by category of medical spending

- Inpatient hospital, medical/surgical, and maternity;
- Inpatient post-acute, rehab., and nursing facility;
- Outpatient care;
- Outpatient care behavioral health
- Primary care;
- Primary care behavioral health;
- All other physician and professional services
- Long-term services and supports;
- Pharmacy; and
- Other medical

Annual expenditures by sub-group

- Health risk score
- Age group
- Gender
- County

Aim 3 analytic approach: volume & price

Price & Volume (utilization-based)	
Volume	Number per 1000 patients: Inpatient days, nursing facility days, ED visits, outpatient visits, other professional or primary care visits
“Price and intensity”	Price per day or visit: inpatient days, nursing facility days, ED visits, outpatient visits, other professional or primary care visits
Price & Volume (episodes of care)	
Volume	Number of episodes per 1000 patients: <ul style="list-style-type: none"> ▪ Select Altarum episodes ▪ Other states have examined: knee replacement, pulmonary embolism, spinal fusion, simple pneumonia, heart stent, heart arrhythmia, knee MRI, colonoscopy, upper GI endoscopy, evaluation & management visits, MRI scan of brain, echo-cardiogram
Price	Price per episode: Same as above

Can assess **utilization-based** volume and price separately for each year by payer, health plan, and provider group. **Altarum episodes** to be stratified by provider type (hospital v clinician) and payer (Medicaid v commercial), 7/16-6/17 only