Rhode Island Health Care Cost Trends Steering Committee

10th Meeting

September 4, 2019

Agenda

1. Welcome!
2. Phase II of the Cost Trends Project
3. Data Use Strategy Implementation
4. Sustainability
5. Break
6. Revisiting the Target Methodology
7. Updates
8. Public Comment
9. Next Steps and Wrap-Up

Welcome!

Welcome!

- Welcome to the first Steering Committee meeting of Phase II of the Cost Trends work.

- During Phase I we:

1. **established a cost growth target**, and developed an implementation manual containing technical specifications for reporting;
2. studied and tested the ACPD and produced initial analyses **demonstrating APCD viability for analyses of cost drivers and cost trend drivers**, as well as analyses that could support cost growth reductions and quality improvement, and
3. created a **plan for the design and production of APCD reports** intended to inform and motivate improved health care system performance.

Phase I Steering Committee Members

We appreciate all of you for having given your time, attention, intellect and judgement to this process and your continued commitment.

Tim Babineau, MD, Lifespan
Al Charbonneau, RI Business Group on Health
Tom Croswell, Tufts Health Plan
Adriana Dawson, Bank Newport
Jim Fanale, MD, Care New England
Stephen Farrell, United Healthcare of New England
Marie Ganim, PhD, Co-Chair, Office of the Health Insurance Commissioner
Peter Hollmann, MD, Rhode Island Medical Society
Kim Keck, Co-Chair, Blue Cross Blue Shield of RI
Al Kurose, MD, Co-Chair, Coastal Medical
Peter Marino, Neighborhood Health Plan of RI
Betty Rambur, PhD, RN, FAAN, University of RI School of Nursing
Sam Salganik, Esq., RI Parent Information Network
John Simmons, RI Public Expenditure Council
Neil Steinberg, RI Foundation
Teresa Paiva Weed, Esq., Hospital Association of RI
Larry Wilson, The Wilson Organization, LLC

New Steering Committee Members

We also would like to thank new Steering Committee members for joining us for the second phase of this work.

- **Angela Bannerman Ankoma**, Executive Vice President, Director of Community Investment, United Way
- **Tony Clapsis,** Vice President, CVS Health
- **Diana Franchitto,** President and CEO, Hope Health
- **Alema Karim, PhD,** Chair of Economics and Finance at Rhode Island College
- **Jim Loring,** CFO, Amica Mutual Insurance Company
- **Patrick Tigue,** Medicaid Program Director, Rhode Island EOHHS

Phase II of the Cost Trends Project

Phase II of the Cost Trends Project

- The Peterson Center on Healthcare informed the Governor on August 1st that it was awarding a second grant to Brown University to support further Cost Trends Project work.

- Peterson awarded an 18-month grant, effective September 1, 2019.

- The following slides provide an overview of the planned work for the 18-month period.

Phase II of the Cost Trends Project

1. **Data Use Strategy Implementation**
   - Design standard reports for routine production as outlined in the Data Use Strategy finalized in the spring. These will be developed in priority order as outlined in the Data Use Strategy.
   - Research report design options and convene an advisory group on report design once per month to provide input to Brown report developers.
   - Vet findings with payers/providers.
   - Put reports into regular production and make them available online.
   - Identify appropriate stakeholders to review report findings.

Phase II of the Cost Trends Project

1. **Data Use Strategy Implementation (cont'd)**
   - Consider report results and make recommendations to act upon report findings.
     - The Steering Committee shall deliberate on the translation of analyses into action by a range of potential parties.
     - The State shall be responsible for translating analyses into action. This will be done considering feedback of the Steering Committee, state agencies, and other RI stakeholders, as appropriate.

= involvement of the Steering Committee

Phase II of the Cost Trends Project

2. Perform Ad Hoc Analyses

- ★ These will be conducted as requested by the Steering Committee to address policy questions and by the State to inform and support regulatory functions.

3. Cost Growth Target Implementation

- Finalize the cost growth target implementation manual, which includes a formal request to collect data from payers, including Medicaid *(completed).*
- Host forums to educate insurers about the data request, starting with baseline data, and begin collaborative work to obtain needed data *(completed).*
- Collect baseline 2017 and 2018 data (October-November 2019).
- Assess performance against the cost growth target for 2019 (Q4 2020).
- ★ The Steering Committee shall review baseline and Year 1 analyses.

Phase II of the Cost Trends Project

3. Cost Growth Target Implementation (cont'd)

- Develop a definition of "significant changes in the economy" that could trigger re-visiting the cost growth target before 2023 considering input from the Steering Committee.
- Update the cost growth target implementation manual to include a recommended process for defining the cost growth targets for CY2023 and beyond (Q1 and Q2 2020).

Phase II of the Cost Trends Project

4. Stakeholder Engagement

- Add additional stakeholders to the Steering Committee *(completed).*
- ★ Hold quarterly Steering Committee meetings.
- Convene monthly provider collaborative meetings to discuss and apply new standardized report findings to improve health system performance (beginning summer/fall 2020).
- ★ Present findings of analyses to legislators and staffers.
- Hold annual public meetings

Phase II of the Cost Trends Project

5. **Sustainability**
   - Perform outreach to the state's largest TPAs and employers to solicit their support to submit claims data to HealthFacts RI *(in progress).*
   - Plan for budgeting and staffing of required functions to continue the work of the Cost Trends Project after the grant period.
   - Develop documentation and provide training to assist the State with assumption of responsibility for a) APCD-based reports and b) analysis of payer reporting to assess cost growth target performance.

Scope of Steering Committee Work

- During Phase II, the Steering Committee will advise the State on the following topics:
  - methodological and reporting questions related to the cost growth target;
  - direction and presentation of intensive analytics;
  - oversight of the data use strategy, and
  - coordination of quality work with the cost trend work.

- In the fall, the Steering Committee will also begin to discuss a structure to institutionalize the cost trends work (e.g., could the HCPAC be a means to institutionalize the project)?

Data Use Strategy Implementation

REPORT DESIGN WORK GROUP

AD HOC ANALYSES

Report Design Work Group

- To implement the data use strategy finalized during Phase I, Brown is convening a new Report Design Work Group.
- The work group will collaborate with Brown University to consider what report designs are most effective for routine publication, advise on refinements to reports, and discuss what ad hoc analyses may be of value.
- It will also discuss statistical considerations, and processes for vetting report results with providers prior to publication.
- The work group will meet once a month for 1.5 hours from October through March, with additional meetings anticipated to occur less often after March.

Report Design Work Group Participants

BCBSRI – Matt Collins

Brown Ctr for Informatics – Neil Sarkar

Brown Physicians – Jay Schuur

BVCHC – Jon Mudge

CharterCare – Kim Labarbera and Bill Webb

Coastal – Mice Chen and Ed McGookin

EOHHS – Kim Paull

Hilb Group – Rob Calise

IHP – Michael Lichtenstein

Integra – Melanie Brites and Matt Harvey

Medicaid – Rebecca Lebeau

PCHC – John Gates, Andrew Saal, and Ed Smith

Prospect – Garry Bliss and Chris Dooley

RIBGH – Al Charbonneau

RIPEC – John Simmons

RI Medical Society – Peter Hollmann

RIPCPC – Andrea Galgay

RIPIN – Shamus Durac

Ad Hoc Analyses

- The Data Use Strategy notes that there are two types of Cost Trends Project-related analyses that can be performed with HealthFacts RI data.

1. A series of routinely produced, commonly structured analyses to be published on a regular schedule *(outlined in the Data Use Strategy).*
2. Ad hoc analyses focusing on discrete topics of interest to the State and Rhode Island stakeholders.

- The Steering Committee will discuss an approach to these analyses during a future meeting.

Sustainability

Sustainability

- As discussed earlier, the Peterson Center on Healthcare has enthusiastically committed to 18 months of continuing support to the Cost Trends Project.
- We have previously anticipated the need to secure funding for ongoing support through the Governor's budget and legislature, and perhaps through private funders, and will be seeking your guidance and support as we discuss this during future meetings.

Break

Revisiting the Target Methodology

When to revisit the target methodology?

In the ***Compact to Reduce the Growth in Health Care Costs and State Health Care Spending in Rhode Island*** the Steering Committee wrote:

- "Only highly significant changes in the economy will trigger re-visiting of the target methodology. The Steering Committee will work with the state to determine a functional definition of "highly significant" and develop a plan for handling such events."

This was added to the Compact in an attempt to address the possibility of a sudden sharp decline in the economy, as we saw occur about 10 years ago.

What is the relationship between the economy and health care spending?

We performed some research and consulted with David Cutler (Harvard economist) on the relationship between the economy and health care spending. (Research summary available in the appendix to these slides.)

<u>The bottom line is:</u>

1. We know that the economy (whether measured through inflation, GDP or personal income growth) affects health care spending. When the economy goes down, so too does health care spending (and vice versa).
2. We also know the effect lags in for each of the indicators by 2-6 years (depending on the indicator), with a margin of 1-3 years.

Central Question for the Steering Committee

Given what we know about the relationship of the economy to health care spending, **should the Steering Committee make a change to the health care cost growth target (which has been set for the next three years) for large changes in inflation, GDP or personal income growth?**

The Steering Committee Co-Chairs recommend not making any changes, because the lag in the relationship is significant and any significant change in the economy will not affect health care spending in the near term.

This would mean that, counter to the compact language, highly significant changes in the economy would not trigger re-visiting of the target methodology for the multi-year target period (but could influence future multi-year cost target periods).

Updates

MISSING DATA

PROVIDER ATTRIBUTION

IMPLEMENTATION MANUAL

TME CALCULATION

Updates on Missing Data from the APCD Analyses

- During the 4/15 Steering Committee meeting, we shared analyses of the APCD. These analyses revealed a few areas of missing data.
- During the 5/14 stakeholder meeting, we shared that the State was in the process of updating these missing data in the APCD.
- Since then...

1. We received updated BCBSRI and UHC data into the APCD. Brown will shortly receive the new data.
2. Onpoint could not replicate the NHPRI inpatient data issue that Brown identified. We found that there was an issue with how Brown was viewing the data. When looking at only commercial members in Rhode Island with 12 months of continuous enrollment, the inpatient values are consistent between Brown's calculations and the underlying APCD data.

Provider Directory Data:
Aggregation & Attribution

Brown University

“Two-Step” Process

- **Objective:** To attribute patients in the Rhode Island APCD to the appropriate primary care physician (PCP) for the year 2017

- **(1) PCP directory aggregation**
  - Compile provider directory data supplied by four payers (**UHC, BCBSRI, Tufts, NHPRI**) into one dataset that can be used for the patient-to-PCP attribution process
  - The resultant dataset to have each record correspond to ONE UNIQUE PROVIDER

- **(2) Patient-to-PCP attribution**
  - Merge dataset from Step (1) to the APCD data
  - Run a programming algorithm to attribute Rhode Island’s patients to an individual PCP

(1) PCP Directory Aggregation – Data Structure & Formatting

- **Each record in each payer's provider directory has unique (NPI) x (PCP Site Name) combinations with various data on where each provider practices and with whom they have contractual relationships**

- **Variation across payer data submission in:**
  - Data entry format
    - For example: IRA WILSON vs. Ira Wilson
  - Level of detail and use of acronyms
    - For example: North Providence Clinic vs. N Prov Clinic vs. Green University N Prov Clinic
  - Inclusion/exclusion of middle names
    - John Peterson Doe vs. John Doe vs. Jonathan P Doe
  - Many more challenges!

(1) PCP Directory Aggregation – Method

- **Append the four payers' datasets together**
- **Clean and standardize the variables (both manually and with software)**
- **Restructure the dataset from a long format to a wide format**

"Long"

First Name	Last Name	Cred	PCP Site	ACO
Hace	Oh	PA	Green #1	Amazing ACO
Hace	Oh	PA	Green #2	Amazing ACO
Anya	Wallack	MD	Brown #1	Best ACO
Anya	Wallack	MD	Brown #3	Best ACO
Deepak	Adhikari	MD	Brown #2	Best ACO

"Wide"

First Name	Last Name	PA	MD	Green1	Green2	Brown1	Brown2	Amazing	Best
Hace	Oh	Yes	No	Yes	Yes	No	No	Yes	No
Anya	Wallack	No	Yes	No	No	Yes	Yes	No	Yes
Deepak	Adhikari	No	Yes	No	No	Yes	No	No	Yes

(1) PCP Directory Aggregation – Lessons Learned

- **There is need for further standardization of:**
  - Data entry formatting
  - Naming of
    - Providers
    - Provider Sites
    - Larger Provider Organizations
    - All other pertinent variables
- **Automated processes and minimal use of manual procedures will lead to increased efficiency and accuracy of APCD provider directory maintenance**

NEXT: Patient-to-PCP Attribution

(2) PCP Attribution – Needed materials

- **Aggregated PCP directory dataset (from “Step 1”)**
- **APCD claims data (merge with PCP directory dataset)**
- **Statistical programming software**

(2) PCP Attribution – Method

- Based on an algorithm developed by RTI which attributes a patient to a provider for each month in a given year

- For each R.I. resident, we count visits to primary care physicians (PCPs) over a 27-month “look-back” period for each month of attribution

(2) PCP Attribution – Method

CPT-4 Codes to Identify Eligible Visits
Evaluation and Management - Office or Other Outpatient Services • New Patient: 99201-99205 • Established Patient: 99211-99215
Domiciliary or Rest Home Care • New Patient: 99321–99328 • Established Patient: 99331–99337
Home Visit • New Patient: 99341–99345 • Established Patient: 99347–99350
Preventive Medicine Services • *New Patient: 99381–99387 ** • *Established Patient: 99391–99397 **
Annual Wellness Visit • Welcome to Medicare visit: G0402 • *Initial: G0438 ** • *Subsequent: G0439 **

(2) PCP Attribution –
Results & Lessons Learned from 2017

- We identified approximately 1400 unique attributed PCPs from our set of OHIC datasets
- We sampled 689,409 unique patients from the APCD database (patients eligible for our project work)
- Out of these 689,409 unique patients:
  - 87.6% were attributed to a provider, overall, inclusive of providers not listed in our set of OHIC datasets.
  - 76.3% were attributed to a provider in our set of OHIC datasets
  - 12.4% were not attributed to a provider

Next Steps

- **Work with Neil Sarkar's team to develop computer algorithms for autonomized maintenance of R.I. provider directory data**
  - Validity check with 2017 data
  - Apply to future provider directory data

- **Execute attribution algorithm with 2018 data**

Implementation Manual

On July 31st OHIC made a formal request of insurers to submit data to calculate performance against the health care cost growth target, and shared the final implementation manual and posted it online.

- The request was made of BCBSRI, NHPRI, Tufts Health Plan and UnitedHealthcare.

Details of the request are posted here:

http://www.ohic.ri.gov/ohic-reformandpolicy-costtrends.php

Data are due to OHIC by 10/1/2019.

Update to TME Calculation

While the Implementation Manual was being finalized, we found a methodological issue which we changed based on the agreement of the Project Team and the Steering Committee co-chairs.

The Steering Committee compact stated that: behavioral health carveouts were to be excluded from the spending calculation because ***"most behavioral health coverage in Rhode Island is provided through the insurer, be it for insured or self-insured business, and will be included in the calculation of total health care spending. Steering Committee members noted that the behavioral health carveout spending is small and the trend is stable."***

Update to TME Calculation

When the Steering Committee had originally considered this issue, members believed that there was likely only a few employers who had carved out behavioral health benefits.

However, because we had previously developed a process for insurers to estimate (using sound actuarial principles) the claims payments for carveout services, we instructed insurers to estimate behavioral health carveout spending in the same manner as is done for pharmacy carveout spending, and in the same manner as MA and DE.

Steering Committee staff and the Steering Committee co-chairs believed this change met the intent of the Steering Committee.

Update to TME Calculation

In addition, we also came to learn that Optum is providing behavioral health benefits for UnitedHealthcare and for NHPRI as a carveout contractor.

If United or NHPRI have access to the behavioral health claims paid by Optum, they will be included. When they do not, they will be estimated using the process previously described.

Public Comment

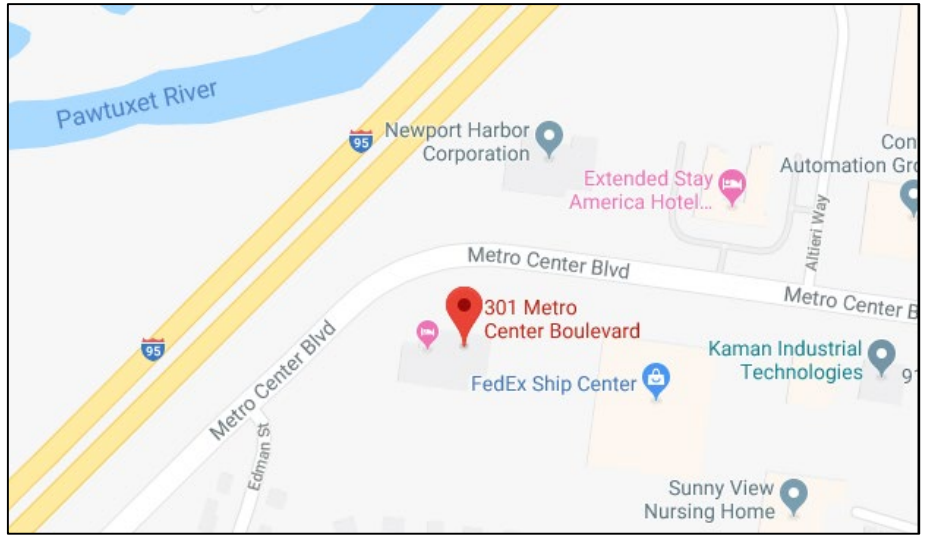
Next Steps

Wrap-Up and Next Meetings

Where: 301 Metro Center Blvd, Suite 203, Warwick, RI 02886

When: *Mondays from 9:00 a.m.-12:00 p.m.*

- December 2, 2019
- March 23, 2020
- June 8, 2020
- September 21, 2020
- December 7, 2020



Appendix

The Relationship Between the Economy and Health Care Spending

We found three reputable analyses that look at the relationship between the economy and health care spending.

We can confidently say that the economy does indeed affect health care spending, and that there is a strong relationship between certain economic indicators and the economy, but the effect on health spending occurs over an extended period of time.

The next few slides summarize the evidence we found from these two reports:

1. *Assessing the Effects of the Economy on the Recent Slowdown in Health Spending* (2013) Kaiser Family Foundation and Altarum Institute
2. *Health Spending Growth: The Effects of the Great Recession* (2015) The Brookings Institution
3. *The Growth of Health Spending in the USA: 1776-2026* (2017) Thomas Getzen, Temple University

What is the Relationship Between the Economy and Health Care Spending? A National Perspective

Kaiser and Altarum developed a statistical model to track how the growth in national health spending varies with macroeconomic indicators and found a strong relationship between inflation and real GDP and health care spending over an extended period of time.

- 85% of health care spending growth could be predicted using inflation and real GDP over the period 1965-2011.

This model also showed that the effect of the macroeconomy on health care spending lags economic change:

- GDP affects health care spending over a period of six years, and inflation does so over two years.

The Great Recession

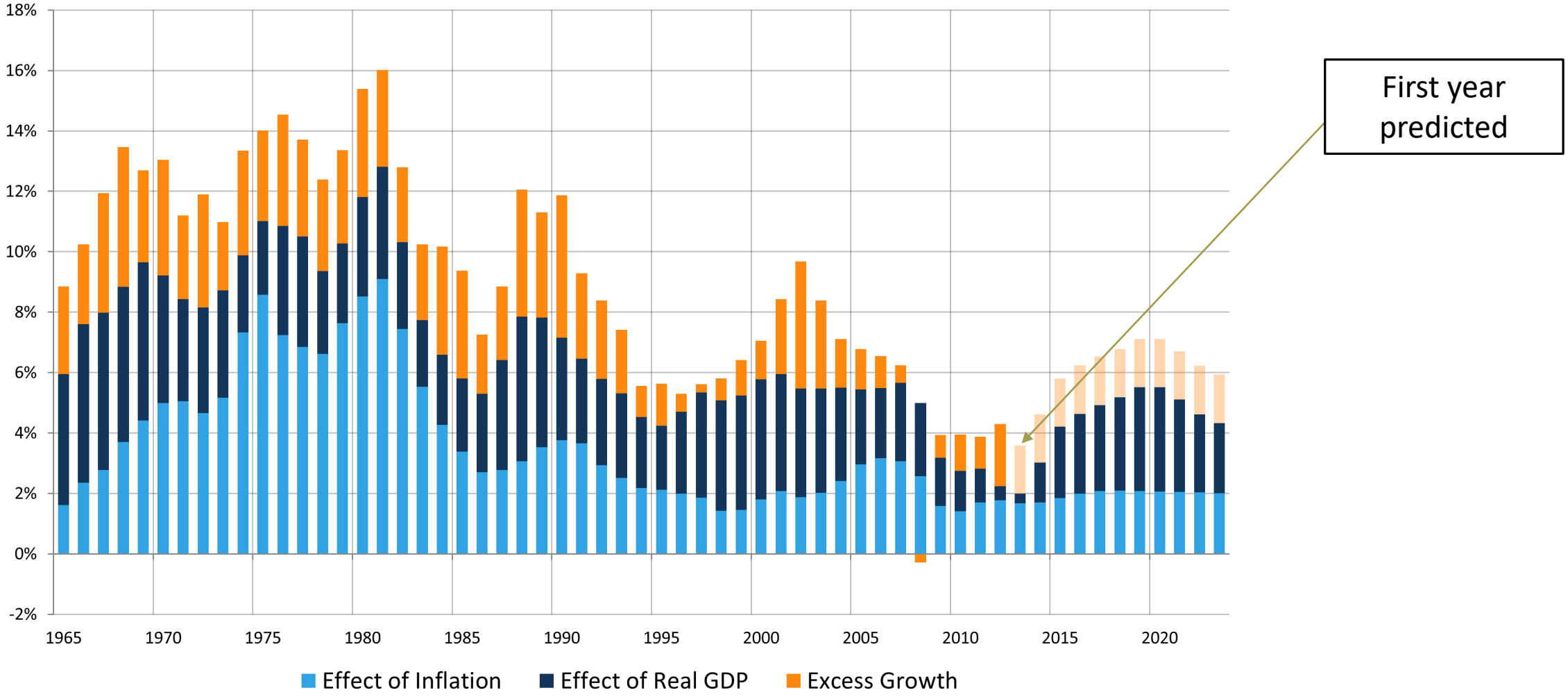
Because the Steering Committee may be most concerned about the impact of dramatic, severe economic changes, it is instructive to look at the impact of the Great Recession.

When applying this model to examine the effect of the Great Recession on the slowdown in health care spending, Kaiser and Altarum found:

- 77% of the decline in health care spending that followed the Great Recession could be predicted based on inflation and real GDP.
- They did not report on how the lagged impact did or did not change during this period.

How fast health spending grows also depends on the level of "**excess health spending"** – which is spending growth that exceeds what GDP and inflation predict, and may be due to structural changes in the health care system.

Actual and Projected Growth in Health Spending by Inflation, Real GDP and Excess Growth



A State Perspective

While the Altarum/KFF analysis looked at national spending against national economic indices, a natural question may be whether state-level economic changes affect health care spending.

Louise Sheiner from Brookings analyzed the effect on growth of state health spending on growth of current and lagged personal income growth.

Personal income growth is the total income received by, or on behalf of, all persons from all sources (including wages, SSI, employer benefits, etc.)

- States track personal income growth as a measure of a state's economic trends, as state revenue depends on personal income and spending on government assistance programs.
- This is different than looking at GSP, which is the total value of good produced and services provided in the state, however, personal income growth and GSP tend to have similar forecasts.

State Perspective: Key Findings on Non-Medicare Spending

- Dental spending is the most responsive to income growth, then, in order of responsiveness, is spending on hospital services, physicians and Rx.
- Changes in hospital spending due to personal income takes about six years.
- Changes in Rx spending due to personal income are immediate.

Source: L. Sheiner, Brookings Institution www.brookings.edu/wp-content/uploads/2016/06/HealthSpendingGrowth.pdf

More Information About Lagging Effects

Thomas Getzen reviewed historical and contemporary sources to trace the growth of national health expenditures in the US from 1776 (yes!!) to 2026 and found:

- There are lags between macroeconomic fluctuations (like GDP, inflation) and changes in health spending of between 3-6 years (with 1 to 3 years margin of error). This supports the Altarum and Brookings findings.
- "The arrival of the great recession in 2008-2010 made it abundantly clear that business cycles affect national health spending."