Rhode Island Health Care Cost Trends Project
Stakeholder Meeting to Discuss Data Analysis and Use Strategies
Meeting Summary
May 14, 2019 | 8:00am-12:00pm

Cost Trends Project Overview

- Marie Ganim shared that the vision of the project is to provide Rhode Island citizens with high-quality, affordable health care through greater transparency of health care performance and increased accountability by key stakeholders.
- She shared the three work streams for the project:
    - **The cost growth target:** The methodology for a health care cost growth target was to be developed for operationalization in 2019. This work was completed in December 2018.
    - **The data analysis:** Brown University was to conduct a data analysis to measure health care system cost performance and identify cost drivers. She said that some of the results from the analyses would be shared at the meeting.
    - **The data use strategy:** A data use strategy will be developed to leverage the RI APCD on an ongoing basis in identifying cost drivers and sources of cost growth variation to improve health care system performance. She said that attendees would discuss the draft data use strategy during the meeting.

All-Payer Claims Database (APCD) Analyses

- Ira Wilson shared initial analyses of APCD data. He noted that the findings from this presentation should not be used for citation due to missing data, but could test the APCD as a data source for the following:
    - total cost trends analyses (the APCD is not sufficiently complete for this purpose at this time);
    - analyses of cost drivers and cost trend drivers (the APCD is a rich source of data for such analyses); and
    - analyses that could support cost growth reductions and eventually quality improvement (the APCD is a rich source of data for such analyses).
- **Structurally missing data** include non-claims payments, a small but increasing component of cost; and 2) self-insured data following the *Gobeille* decision. Ira Wilson said that the missing self-insured data are significantly different from the self-insured data that remain in the APCD.
- **Deconstruction costs and cost trends:** Ira Wilson presented analyses demonstrating the possibility of using the APCD data to understand drivers of costs and drivers of cost trends. He shared that drugs are a large driver of cost trends in the commercial market. He illustrated how APCD data could be used to drill down and understand what drug categories and specific drugs were driving the increase in drug costs.
    - A meeting participant asked if it was the price or utilization of the drug influencing the cost growth in this area. Ira said that it has been both.
- **Low-Value Care:** Ira Wilson illustrated how low-value care could be identified using the APCD. His examples showed how rates of low-value care and variation across payer

market segments are substantial. Better understanding these areas would allow for opportunities to reduce unnecessary costs.
    - One participant asked if any of the variation by market segment could be due to differences in data entry. Ira Wilson said that there are limitations to using claims data, but that does not make the analyses invalid. He noted that you would not expect to see change over time if variation were due to data entry.
    - Another participant asked if most low-value services were ordered in the emergency room. Orestis Panagiotou said claims do not indicate who ordered the test.
- **High Opportunity Care Episodes:** Ira Wilson shared that the APCD could be used to analyze episodes. He shared data on total knee replacements (TKR). For the analysis, they defined the episode as all costs associated with the hospitalization only. The analysis showed that utilization rates were stable, with about 200 TKRs done each month. There was variation by payer in rates. He also showed an analysis demonstrating cost variation at the hospital level for TKRs paid for by commercial payers.
    - One meeting participant asked if Brown analyzed the cost variation by hospital to test for statistical significance. Ira Wilson said they had not looked into that yet, as the example was intended to be illustrative of how the APCD could be used to look at variation in costs.
- **Volume vs. Price:** Ira Wilson demonstrated how the APCD could be used to look at components of cost to better understand whether cost trends were based on changes in utilization or price. He noted that the data show different pattern of price and utilization across market segments.
- **Attribution:** Ira Wilson said that the ability to compare all-payer performance of provider groups is a critical innovation. Since the patients in the APCD are de-identified, Brown used patient utilization data to link patients to providers. These providers are then linked to provider groups/ACOs using data from the Office of the Health Insurance Commissioner (OHIC). In 2017, about 12.4% of patients were unattributed. This could be due to lack of a PCP visit or attribution to a PCP who is not in the OHIC dataset.
    - One participant asked about the methodology for breaking a tie in the attribution. Ira Wilson said that in the case of a tie, a patient would be attributed based on the most recent visit.
- **Discussion**
    - <u>Clarification Questions:</u>
        - One participant asked when attribution would be complete. Ira Wilson said that using the data available now, Brown will have done everything it can do within a month or two.
    - <u>Data Accessibility:</u>
        - One participant asked about accessibility of the APCD data. Neil Sarkar said that the Brown Policy Lab has built a restricted environment to store APCD data for projects being done by academic institutions. The Lab is currently trying to understand how to make efficient data sets to support researchers.
        - Another participant raised concerns about the accessibility of sensitive marketing information in the APCD.

- Additional Areas of Exploration:
    - One participant noted the importance of considering specialty groups in analyses.
    - Another participant noted value in being able to link family groups when looking at costs. Neil Sarkar and Ira Wilson noted that this would require many linkages that are not currently available in the APCD.
    - Another participant recommended using APCD data to look at quality and outcomes.
    - Another participant asked if the data would allow Brown to look at the impact of prior authorizations and other payer policies. Ira Wilson said that these kinds of data are not in a claims data set.
    - Another participant recommended looking into best practices and benchmarks as points of comparison for Rhode Island analyses.

Washington Health Alliance Experience with Claims Data Analysis and Reporting

- Nancy Giunto shared the Washington Health Alliance's (WHA's) experience collecting and reporting on multi-payer claims data. As background she shared that WHA is a multi-stakeholder organization that is represented by 185+ member organizations statewide. The WHA has two core competencies 1) convener for stakeholders and 2) performance measurement and reporting. Most of the data for the work comes from a voluntary multi-payer database to which there are currently 35 data submitters. Medicare data are not included in the database. The database represents about 2/3 of the state's population.
- Nancy Giunto shared four types of reports produced by WHA.
    - **Community Checkup** provides a market-view of payer and provider performance on over 100 quality and patient experience measures. This is where performance on the state's common measure slate is reported. Analyses are reported on at the state level, county level, health service area level, payer category, and medical groups/clinics (for those with four or more providers), and hospitals.
    - **New Alliance Pricing Reports** examine hospital variation and spending trend analysis.
        - Nancy Giunto shared an example analysis examining price variation and infection rate for TKRs across hospitals.
        - For its spending trend analyses, WHA looked at two volume-related drivers (membership and service frequency) and two price-related drivers (service intensity and unit price).
    - **First, Do No Harm** reports on low-value services using a Health Waste Calculator developed by Milliman. WHA expanded on these findings to create the "Drop the Pre-Op" campaign in response to findings in their report.
        - WHA has also encouraged purchasers and plans to stop paying for service identified as the top 10 waste areas in the state.
    - **Different Regions, Different Care** displays geographic variation in use of services.
- **Discussion:**
    - WHA's Processes:

        - One participant noted the robust committee structure used by WHA and asked when WHA created the committee structure. Nancy Giunto shared that the committee structure was developed early on in their work.
        - One participant asked about WHA's relationship to state government. Nancy Giunto said that WHA works closely with the state as a partner.
    - Provider Engagement:
        - One participant asked how WHA worked with providers to make data actionable. Nancy Giunto said that Ron Sims is a champion of this work and set a framework to bring a robust and well-rounded group of representatives to the table. She said that any proposed analyses are brought to both their Quality Improvement Committee (clinicians) and the Health Economics Committee (multi-stakeholder group with actuaries and brokers and plan leaders) for review and input. Creating buy-in and having stakeholders participate in the design of the analyses makes it more difficult for providers to shy away from report findings later on.
        - One participant asked if WHA experienced resistance from the community when sharing price variation among named hospitals. Nancy Giunto said that WHA did not receive negative pushback due the fact that senior leadership from hospital systems are on the WHA board and due to the trust that has built with providers over time.

Proposed ACPD Data Use Strategy

- Michael Bailit said that there are 16 operational state APCDs as of January 2019 with relatively few being effectively leveraged to propel improved health care affordability and quality. He said the goal for this portion of the agenda was to discuss a strategy to effectively use RI's APCD to improve value.
- Michael Bailit said that in November 2018, the Cost Trends Project hosted a meeting to discuss ways to leverage the APCD. The key recommendations emerging from the meeting were as follows:
    1. actively and continuously engage stakeholders;
    2. responsibly test and then release data;
    3. develop a sustainable funding model;
    4. make unwarranted variation transparent;
    5. identify cost drivers, and
    6. consider the development of a community analytics resource.
- Following the November conference, the RI Cost Trends project team had follow-up conversations with the November meeting presenters, held provider focus groups, facilitated multiple Steering Committee conversations about priorities for use, and distributed the draft data use strategies for comment by stakeholders.
- **Scope:** The Steering Committee considered two types of analyses: 1) routinely produced, commonly structured reports and 2) ad hoc reports. The data use strategy focuses on routinely produced reports.
- **Key Decisions:** The Steering Committee agreed upon the following when shaping its recommendations:
    1. Prioritize reports first for provider use, and second for the general public, inclusive of employers, policy makers and other interested parties..

2. Don't focus on payers and consumers as priority audiences. Payers already possess claim data, and research repeatedly shows consumers don't use health care performance data.
    - Two participants pushed back on the idea of not focusing on payers and consumers. One mentioned the need to use data to ensure affordability and another noted that there is a place for consumer engagement in costs.
3. Generate reports that isolate what is driving underlying cost and what is driving cost growth, with the former the highest priority.
4. Because there is already significant RI measurement activity related to quality, and some degree of related transparency, focus first on measurement associated with spending.

- **Prioritized Analyses:** Michael shared that the Steering Committee recommended focusing on five types of analyses, in priority order:
    1. Cost drivers
        a. utilization variation
        b. price and cost variation
    2. Cost growth drivers
    3. Cost drivers (cont'd)
        a. Low-value services
        b. Potentially preventable services
    4. Population demographics, including SDOH
    5. Quality of care
- **Discussion**
    - <u>Prioritized Analyses:</u>
        - One participant recommended prioritizing analyses that would not be impacted by the lack of non-claims data in the APCD while waiting for these data to be added.
        - One participant recommended analyzing practice pattern variation as a way to engage specialists given their high contribution to health care costs.
        - One participant recommended supplementing ongoing analyses with purchased Milliman data for benchmarking.
    - <u>Actionable Results:</u>
        - One participant asked how the reports would result in action. Marie Ganim noted that increased transparency could influence legislation and action by stakeholders. Al Kurose said that provide transparency would put pressure on providers to act on results.
        - One participant asked how external benchmarks could be used to drive action. Michael Bailit said that potential benchmark sources include other state multi-payer claims databases and benchmarks produced by companies like Milliman. He recommended that discussions of benchmark sources involve technical experts so appropriate benchmarks are selected.
    - <u>Sustainability:</u>
        - A few participants expressed concerns about sustainability of the work.
        - One participant recommended adding structure to the process by which the data use strategy will be implemented. Michael Bailit agreed and said

that ultimately this work will need to move from a project to a set of institutionalized practices. He recommended considering processes and governance in the next phase of the RI Cost Trends project work.
        - One participant recommended using analyses to open discussions with providers on accountability. Michael Bailit also said the reports would provide the opportunity for collaborative problem solving and performance improvement efforts.
        - One participant said that providers have been tackling these issues independently and may benefit from open dialogue across providers about best practices and patterns in the data.
    - Communications:
        - One participant recommended more clearly communicating the data use strategy and its intent to Rhode Island stakeholders and to include more diverse voices in discussions about the data use strategy.
        - One participant noted it would be important to frame cost in relation to quality and noted that reports could reference existing work done in the state on quality.

Wrap-Up and Next Steps

- Kim Paull said that the State is trying to find a high leverage entry point for the APCD into the health system. She said based on Brown's interrogation of the data, the State knows more about the APCD and its data than ever before. She recommended continuing interrogation of the APCD and considering what role the APCD will play in the state's health care system.