Rhode Island Health Care Cost Trends Project
Steering Committee Meeting Summary
301 Metro Center Blvd., Suite 203, Warwick
April 15, 2019
9:00am – 12:00pm

Steering Committee Attendees:
Mark Adelman (for Tim Babineau), Lifespan
Al Charbonneau, Rhode Island Business Group on Health
Tom Croswell, Tufts Health Plan
Amanda Davis (for Peter Marino), Neighborhood Health Plan of Rhode Island
Stephen Farrell, UnitedHealthcare of New England
Marie Ganim, Co-chair, Office of the Health Insurance Commissioner
Kim Keck, Co-chair, Blue Cross Blue Shield of Rhode Island
Al Kurose, Co-chair, Coastal Medicine
Teresa Paiva Weed, Hospital Association of Rhode Island
Betty Rambur, University of Rhode Island College of Nursing
Sam Salganik, Rhode Island Parent Information Network
Larry Wilson, The Wilson Organization
Peter Hollmann, Rhode Island Medical Society

Steering Committee Members Unable to Attend:
Adriana Dawson, Bank Newport
Jim Fanale, Care New England
John Simmons, Rhode Island Public Expenditure Council
Neil Steinberg, Rhode Island Foundation

Steering Committee Staff Attendees:
Cory King, Office of the Health Insurance Commissioner
Kim Paull, Executive Office of Health and Human Services
Orestis Panagiotou, Brown University
Anya Rader Wallack, Brown University
Ira Wilson, Facilitator, Brown University
Michael Bailit, Facilitator, Bailit Health
Justine Zayhowski, Bailit Health

Welcome

- Marie Ganim shared that the Steering Committee will begin meeting on a quarterly basis after the June meeting.
- Michael Bailit reminded the Steering Committee of the three work streams for the project: 1) development of a cost growth target); 2) an analysis of APCD data to measure health care system and cost performance; and 3) a data use strategy to leverage the APCD in identifying cost drivers and sources of cost growth variation to improve health system performance.

Revisit Data Source for the Cost Growth Target

- Michael Bailit reminded the Steering Committee that in November it deferred finalizing a recommendation on the cost growth target. Since then, Brown's APCD analysis has determined that the data for the missing self-insured population are not comparable to the data of the self-insured population remaining in the APCD. He shared a Steering Committee staff recommendation that performance against the cost growth target be calculated using payer-reported information for the first two years, with the potential for transition to use of the APCD when its more complete.
- One Steering Committee member asked for clarification that the payer-reported data would include non-claims data. Michael Bailit confirmed that it would.
- No one objected to use of payer-reported information to calculate initial performance against the cost growth target.
- **Decision:** Calculate performance against the cost growth target using payer-reported data for the first two years, with the potential to transition to use of the APCD when it is more complete.

APCD Data Analysis Presentation

- Ira Wilson shared initial analyses of the APCD. He said that trends of cost and drivers of cost are distinct. The APCD is not currently a good source for trend analysis due to missing data, but is an excellent source for trend driver analyses that could support cost growth reductions and/or quality improvement.
- **Missing Data:** Ira identified the following key information as missing from the APCD: 1) Medicare FFS Q4 2017 (just received); 2) self-insured data (88,000 lives were lost in January 2016); 3) non-claims data; and 4) additional missing data from certain commercial payers.
    - Self-insured data: Ira Wilson shared that the claims experience of the 88,000 self-insured lives lost due to the *Gobeille* decision was significantly different than the remaining self-insured lives data.
        - One Steering Committee member recommended looking at the impact of age.
        - One participant asked if there had been discussion about what payers could do to hold the self-insured accountable to submit data. Ira Wilson recommended circling back to this at a later time.
    - Non-claims data: Ira Wilson shared that the non-claims payments are in the 3-5% of total spend range. The rates of non-claims payments are going up, so it may be increasingly important to include these data in the APCD moving forward.
    - Data from commercial payers:

        - Data are missing for the BCBSRI self-insured and fully-insured as well as Medicare Advantage in November and December 2015.
        - Data are also missing from UHC in November and December 2015 as well as January through May 2017.
        - Data are missing from NHPRI's fully-insured business in late 2014 and early 2015.
        - Ira Wilson concluded that there are data submission problems across the payers that need to be fixed.
        - One Steering Committee member asked if there was a hypothesis on the missing payer data. Kim Paull said that EOHHS shared the analyses with the BCBSRI APCD team. There is a decimal issue with the November and December data for BCBSRI 2015 and BCBSRI is working to resubmit. Kim Paull noted they were still looking into the NHPRI and UHC data issues.
- **Classification of Individual Patients:** Ira Wilson shared that the data analysis team classified individual patients by primary payer by month. There were a number of cases where they had to make decisions about whether to include secondary and tertiary payers in calculations. The only situations in which secondary payers' claims were included in calculations were for Medicare Advantage and Medicaid FFS duals and Medicare FFS and Medicaid FFS duals.
- **Cost Trends:** Ira Wilson showed an analysis of non-risk-adjusted cost trends across major service category. Drug costs increased 36% in three years. Trends are influenced by missing data, but drug costs are driving total cost increases in a significant way.
    - One Steering Committee member noted that drug costs are understated since some drug costs are included in outpatient costs. Ira Wilson agreed, adding that about 25-30% of prescription drug costs are not in the drug cost category.
- **Low-Value Care:** Ira Wilson shared a number of analyses on low-value care. Overall, there were relatively low rates of low-value care for the services analyzed for 2014.
    - One Steering Committee member said that he works with patients denied services that their physicians feel are necessary. He recommended complimentary analyses of high-value services that are being underutilized.
        - Another Steering Committee member said that the APCD could not be used to conduct these analyses since it there are no claims for services that are not paid.
    - Another Steering Committee member said that there are some areas where Rhode Island has higher utilization than regional and national norms. She recommended looking at utilization data to better understand this.
    - One Steering Committee member asked what the next steps were for low-value care analyses. Ira Wilson said the data analysis team was going to look at all 16 previously identified low-value care services and do so for the period 2014-2017.
        - Another Steering Committee member said there is a broader array of low-value care items being analyzed elsewhere. He mentioned that the Washington Health Alliance uses 44 low-value care indicators in its analyses.
        - One participant shared that Rhode Island is in the second highest quartile for low-value care according to a recent CMS analysis. He said it was

important to get at provider-level data, but even so, those data will still not indicate which provider ordered a test.
    - One Steering Committee member recommended including standard prices for low-value services to get a sense of the impact. He also recommended understanding the rates of low-value services in other communities as comparison points.
        - Another Steering Committee member suggested if rates were similar across communities, there could be an inherent error rate.
- **Trends in Total Knee Replacement:** Ira Wilson shared analyses of total knee replacement episode costs. He notes that in this analysis the "episode" included all costs associated with the hospitalization only. He added that CPT codes could not be used to distinguish between total knee replacements and partial knee replacements. Finally, he observed that the cost trends were relatively flat, but that there was significant variation in costs by payer type and by hospital.
    - Kim Paull noted that payers with standardized pricing, Medicare and Medicaid show less variation than those without standardized pricing.
    - Michael Bailit said we do not know what percentage of episode costs are potentially avoidable, such as those incurred due to avoidable complications.
    - One Steering Committee member asked if there was a way to include ambulatory surgical centers in analyses. Ira Wilson said they could do this.
    - Another Steering Committee member observed that these analyses pointed out some shortcomings of focusing only on cost trends. The trends are flat for total knee replacement, but upon digging into the data there appears to be an opportunity to intervene in this area and reduce variation in costs.
    - Anya Rader Wallack noted that the data analysis team could also look at complicated and uncomplicated total knee replacement rates across facilities.
    - Ira Wilson said he would also like to speak with orthopedists to better understand the issues and what kind of things should be adjusted for.
- **Benchmarking:** The analyses had not yet been compared to benchmarks.
    - One Steering Committee member said that we need to be careful based on our benchmarking and what standards we are using. He thought that this was an important way to frame our thinking.
    - Another Steering Committee member added that when you are doing benchmarking on utilization you could also look at the degree of variation across providers within RI. Granted there may be some case mix issues, but there are other instances where this is not.
    - One Steering Committee member recommended against benchmarking against a broken system. He suggested better understanding how administrative and overhead costs contribute to expenses.
- **Demographic Data:** One Steering Committee member recommended utilizing demographic data in analyses.
    - Anya Wallack said there were limitations in doing this with APCD data, but that there was interest in this expressed during provider focus group discussions. The focus groups recommended mapping the APCD with demographic data sources to better understand issues on which we should focus.
    - Ira Wilson recommended that state resources like CurrentCare be linked to the APCD.

- **Overall Impressions:** Overall, the Steering Committee was supportive of the utility of analyses from the APCD. It did not believe that existing limitations should keep the State from actively pursuing use of the APCD.
- **APCD Analysis Next Steps:** Ira Wilson said in advance of the May stakeholder meeting the data analysis team is hoping to examine: 1) variation in utilization and cost by providers; 2) high-opportunity episodes; 3) out-of-pocket costs; 4) additional low-value care areas.

Data Use Strategy Policy Questions

- Michael Bailit reminded the Steering Committee that the purpose of the data use strategy is to leverage the APCD to improve health care system performance. It is not about assessing performance against the cost growth target.
- Michael Bailit shared that feedback from stakeholders prompted a number of policy strategies. After reviewing these with the Steering Committee, a near final data use strategy will be presented during the May stakeholder meeting.

Topic Prioritization

- Michael Bailit explained that because there are several types of APCD analyses of interest for the data use strategy, it will be necessary to prioritize the order in which they are developed.
- Michael Bailit shared that Steering Committee staff previously ranked prioritization of data use strategies based on the input of those stakeholders who had offered feedback. Upon review, two of the three Co-Chairs (Kim Keck and Al Kurose) expressed some concerns with this prioritization and recommended an alternative approach. He then reviewed the stakeholder-informed priorities, in comparison to Kim and Al's voiced priorities.

Draft 4/8 Stakeholders' Prioritization	Co-Chairs' Recommended Prioritization
1. cost growth drivers 1. quality of care 2. population demographics, including social determinants of health 3. low-value services 3. price and cost variation by service and episode of care 3. utilization variance 4. potentially-preventable services.	1. cost drivers 2. utilization variance (as compared to Milliman benchmarks) 3. cost trend drivers 4. price and cost variation by service and episode of care 5. potentially-preventable services and other low-value services 6. population demographics, including social determinants of health (Defer work on quality-of-care analysis.)

- Kim Keck explained that utilization in Rhode Island is higher than in other states. Given the hospital price growth cap and rich benefit plans in Rhode Island, that is not surprising, but it would be helpful to understand utilization statistics in the state.
- Al Kurose noted that he and Kim made a recommendation since they do this work on a day-to-day basis, but they would not want to impose their priorities on the Steering

Committee. They noted they are willing to accept the Steering Committee's prioritization without hesitation.

- Michael Bailit asked for clarification on how cost drivers differ from utilization and price variation. Kim and Al responded that cost drivers are components of how to reduce total cost of care. Looking at utilization variance and price and cost variations are partial deconstructions of cost drivers. They added that their #1 priority analysis is an umbrella concept, with #'s 2, 4, 5, and 6 falling under that umbrella.
- Cost Drivers: Steering Committee members agreed that cost drivers (or "total cost of care", in the words of one member) should be the highest priority analysis.
- Utilization Variance: Two Steering Committee members expressed support for utilization variance analyses. One of these members noted that it would be important to look at unit price as part of the utilization variance.
    - One Steering Committee member suggested that health plans with utilization data should make their data available across the state.
- Population Demographics, including Social Determinants of Health: One Steering Committee member noted that SDOH data could not come from the APCD. Michael Bailit said that these types of analyses would require layering on an additional data source(s) for supplemental information.
- Quality of Care: One Steering Committee member said that other organizations are producing provider-level data on quality of care. Another Steering Committee recommended that quality of care be high on the priority list.
    - Another Steering Committee member said the APCD is the wrong tool to analyze quality of care. Another Steering Committee member agreed.
    - Another Steering Committee member noted that administrative data-based measures could be calculated using APCD data.
    - Another Steering Committee recommended waiting to pursue quality for a few years, adding that Rhode Island has been working for over a decade on quality of care, whereas work on understanding the cost of care is far behind. He recommended trusting the global oversight of quality on a payer-specific basis for the next few years while the State pursues cost data.
- Price Data: One Steering Committee member noted that price may not be actionable since it is set by other people.
    - Another Steering Committee member expressed concern about the disclosure of price point information.
    - **Decision:** The data use strategy recommendations should include language expressing caution about using price point information.
- Other: One Steering Committee member recommended that any new cost-related analyses be pursued with a quality lens to ensure that quality will not be adversely impacted by potential results of the analyses.
- **Action step:** Steering Committee staff will refine the topic prioritization language to reflect the Steering Committee's discussion.

Should the data use strategy recommend the design of a comprehensive array of reports for routine publication or pilot a limited number of analyses on a few topics of interest?

- Steering Committee Staff Recommendation: Develop a comprehensive array of reports for routine publication.

- **Decision:** The data use strategy recommendations will include language about producing a comprehensive array of reports contingent on having available resources.
- None of the Steering Committee objected to the recommendation.

At what level(s) should these analyses be produced, e.g., practice, hospital, ACO, insurer, insurance market? Should the answer vary based on the type of report?

- Steering Committee Staff Recommendation: Analyses should be produced at the practice, hospital, ACO, insurer, and insurance market levels. Data should not be published when samples sizes are too small for statistical validity, or data are insufficiently complete for the intended use.
  - One Steering Committee member said he agreed with the recommendation.
  - None of the Steering Committee objected to the recommendation.

Should the analyses examine price and cost variation at the service and episode-of-care level, or only at the episode-of-care level?

- Steering Committee Staff Recommendation: Report on both.
  - One Steering Committee member noted that if we did not include price information, the types of analyses the State could do would be limited. They recommended finding a way to balance concerns about the impact of pricing data on competition, but also find a way to benefit from use of the data.
  - None of the Steering Committee objected to the recommendation.

Should data be made available to providers for validation prior to publication?

- Steering Committee Staff Recommendation: Stakeholders, including providers, should be involved in the design and implementation of the data analyses and reports. Provision of data and analyses for provider validation, however, could potentially significantly slow or even halt report distribution. Therefore, an oversight committee should review all work and methodologies, but providers should not validate each report.
  - Two Steering Committee members asked what resources were available for analysis and reporting.
    - **Action step:** Steering Committee staff will discuss resources for analysis and reporting at a future Steering Committee meeting.
  - Another Steering Committee member recommended that there should be ample time for providers to review reports, particularly at the outset.

Should the strategy articulate a longer-term vision to integrate information from the APCD with CurrentCare?

- Steering Committee Staff Recommendation: Yes. Integration of the APCD and CurrentCare would provide a rich resource to the state. This vision won't be feasible in the short-term, as CurrentCare, even more than the APCD, needs to make progress in making its data more complete.
- Kim Paull noted that there are statutory restrictions for both the APCD and CurrentCare that bar using identifiers and linking data.
- One Steering Committee member noted that the ability to link the two databases would leapfrog Rhode Island's analytic capabilities over other states.

Should the strategy specify that the APCD should incorporate non-claims spending data to make the cost analyses complete?

- Steering Committee Staff Recommendation: Yes. Such data are necessary to enhance spending analysis. EOHHS is committed to advancing this policy aim.

Other

- One Steering Committee member expressed confusion about the purpose of the Data Use Strategy Recommendations.
    - **Action step:** The Steering Committee staff will clarify that the Data Use Strategy Recommendations are a series of recommendations on prioritized APCD analyses.

Action step: Steering Committee staff will update the draft data use strategy recommendations based on the Steering Committee's discussion and circulate it in advance of the May stakeholder meeting.

Public Comment

- There were no comments from the public.

Next Steps and Wrap-Up

- Data analyses and a near-final data use strategy will be presented at an invitational stakeholder meeting on May 14 from 8am-12pm at the Hotel Providence.
- The next Steering Committee meeting will take place on June 10 from 9am-12pm at 301 Metro Center Boulevard, Room 203, in Warwick.