Rhode Island Health Care Cost Trends Project
Steering Committee Meeting Summary
301 Metro Center Blvd., Suite 203, Warwick
November 5, 2018
9:00am – 12:00pm

Steering Committee Attendees:
Tim Babineau, Lifespan (for the first half of the meeting)
Al Charbonneau, Rhode Island Business Group on Health
Tom Croswell, Tufts Health Plan
Jim Fanale, Care New England
Stephen Farrell, UnitedHealthcare of New England
Marie Ganim, Co-chair, Office of the Health Insurance Commissioner
Peter Hollmann, Rhode Island Medical Society
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
Neil Steinberg, Rhode Island Foundation
Beth Marootian, Neighborhood Health Plan Rhode Island (for Peter Marino)
Dan Moynihan, Lifespan (for Tim Babineau during the second half of the meeting)
Rebecca Webber, Blue Cross Blue Shield of Rhode Island (for Kim Keck)

Steering Committee Members Unable to Attend:
Adriana Dawson, Bank Newport
Chris Koller, Milbank Memorial Fund
John Simmons, Rhode Island Public Expenditure Council
Larry Wilson, The Wilson Organization

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

Data Use Strategy: 11/14 Conference

Logistics: The 11/14 conference is an invitation-only event. Each Steering Committee member has been invited to attend or send a designee on their behalf. Other participants will include Rhode Island stakeholders not represented on the Steering Committee, project staff and consultants, and representatives of the Peterson Center on Healthcare. Bailit Health is maintaining a waiting list should there be room for additional attendees.

- **Action steps:**
  - Steering Committee members should email Joanne Michaud (joanne_michaud@brown.edu) for a parking reservation by the end of 11/5.
  - Justine will share the list of 11/14 conference attendees with the Steering Committee.

Content: During the morning session, state and organizational speakers will discuss ways they are leveraging multi-payer claims databases. The three major data use categories are: 1) to support ongoing regulatory activity and analysis of potential policy initiatives, 2) to promote transparency for consumers and policymakers with cost and quality reporting and tools, and 3) to support specific regional or provider-level delivery system activity. During the afternoon session, a panel will discuss how providers, payers, and/or the State can leverage Rhode Island's APCD to enhance the value of health care.

Questions for the Speakers/Panelists:

Steering Committee members suggested the moderators ask the following questions of scheduled morning speakers and afternoon panelists:

- For those using multi-payer claims databases to support provider-level activity, do provider entities have access to patient-level data?
- What is the process for reconciling multi-payer claims database results with payer and provider data?
- How is risk adjustment applied?
- How are data collection and analysis financed?
- How has the use of your multi-payer claims database affected affordability in the state?
- What are the main drivers of price growth?
- What are your future plans for use of the data?
- How have you addressed the challenge of obtaining non-claims and self-insured data?

Update on the Analysis of the APCD: The data analysis team received access to the APCD data in usable file formats. They are currently cleaning the data and conducting quality checks, targeting completion next week. Following quality checks, the data analysis team will begin creating key variables, such as patient attribution and patient risk scores. Patient risk scores will be created using 3M software, which has been used by Vermont for a similar analysis.

Cost Growth Target: Data Source Revisited: During the 10/15 meeting, the Steering Committee supported the option of utilizing payer-reported spending calculations for assessing performance relative to the target. Since that time, OHIC, EOHHS and Brown have identified

the need for additional information to fully assess what efforts are required to be able to use the APCD as a foundation for data and what efforts might be required from payers if the APCD is not utilized. Calculations will occur in 2020, so the cost growth target can be set without resolution of the data source decision.

- **Decision:** The Steering Committee will defer finalizing a recommendation on data source for assessing performance until research can be completed.
- **Action step:** Brown will evaluate key questions regarding the data source.

Cost Growth Target: Provider Attribution and Risk Adjustment

Patient Attribution: "Who": On 10/15, the Steering Committee debated use of the ACO contracting unit or the provider-corporate entity as the primary unit of analysis. At that time, payer representatives were tasked with considering the operational implications of reporting patient attribution by ACO. Payers subsequently shared with staff that they are able, and prefer, to report patient attribution by ACO, but noted that not all ACOs are contracted for all lines of business.

- **Decision:** Measure provider performance at the ACO level. Measure performance of all providers not part of an ACO in aggregate. Measure performance of all providers part of an ACO but with small populations in aggregate.

Patient Attribution: "How Many": Bailit Health shared analyses illustrating the impact of random variation by the number of attributed members. Providers with small numbers of attributed patients have higher levels of random variation than those with larger numbers of attributed patients. The Steering Committee discussed the importance of 1) recommending a minimum threshold for attributed population size and 2) setting parameters as to how much variation there needs to be from the cost growth target for the variation to be considered "real."

- Steering Committee members discussed the impact of including/excluding providers with smaller populations.
    - Some members wondered whether there was there were ways to mitigate random variation for small providers. Options include: looking at the same population over time, truncating outliers, and risk adjustment. None of these options fully mitigate the vulnerability of small populations to random variation.
    - Some members wanted to know how much of the Rhode Island population would be excluded by excluding smaller providers.
        - Ira Wilson indicated that if payers provided Brown with data on which patients were attributed to which providers and which providers were part of which provider groups, then Brown could answer the question.
        - Some Steering Committee members noted that the cost growth target would still capture nearly the entire Rhode Island population at the state-level of performance measurement. Others shared that it is important to understand how the analysis at each sub-level related to the state-level measurement.

    - Some members questioned whether there was value in providing provider-level data by payer and by line of business. Michael Bailit noted that if payer-reported data are used, then data cannot be combined across insurers due to risk-adjustment issues. If the APCD data are used, then there is the potential to aggregate data across payers.
- Some Steering Committee members noted the importance of understanding the drivers of the cost growth trend and the impact on affordability.
- Steering Committee members discussed that variability from the target may vary by lines of business. Medicaid and Commercial variation looks similar. Medicare has less variation because the burden of illness in the population is much higher.
- Other Steering Committee members noted that the goal of publicly sharing provider-level information is to promote transparency and standardize measurement.
- Steering Committee members agreed it is important to provide accurate data. The Steering Committee did not support sharing data at the provider level where there was no statistical basis for confidently assessing performance.
- **Decision:** Set the thresholds at 10,000 attributable patients for Commercial and Medicaid populations and at 5,000 attributable patients for the Medicare population.
- **Decision:** Develop parameters around what level of variation from the target should be considered as meaningful deviation.

Risk Adjustment: Michael Bailit shared that risk adjustment should be considered for the assessment of payer and provider performance against the target.

- **Decision:** The approach to risk adjustment will depend on the data source. If the data source is payer-reported, then payers will use their existing risk adjustment methodologies. If the data is reported from the APCD, a common risk adjuster will be used (although it may vary by Medicaid, Medicare and commercial population).

Cost Growth Target: Setting the Target and Timeline

PGSP Value: Megan Burns reminded the Steering Committee that it recommended using potential growth state product (PGSP) to set the cost growth target. She shared Rhode Island's forecasted growth in PGSP (3.2%). She noted that while Massachusetts and Delaware also use PGSP, their values will not be the same as Rhode Island as PGSP considers the state-level variables of potential labor force growth and population growth.

- **Action step:** Marie will share the calculation of PGSP with state finance officials to confirm their agreement with the project team's calculated value.

Adjuster: The Steering Committee discussed whether PGSP should be adjusted for the purpose of setting the cost growth target.

- Some members favored an adjustment down from the PGSP value, stating the importance of reducing growth in health care spending and making health care more affordable.

- Other members favored an adjustment up from the PGSP value, stating that they did want the target to be too aggressive during the first year.
- Other members favored PGSP without an adjustor, stating that using PGSP is consistent with the goal of making sure that health care does not take up an increasing portion of the state budget.
- **Decision:** There will not be an adjuster applied to PGSP at the outset.
    - Dan Moynihan conveyed his dissent. He proposed a target of 3.5%-3.7%.

Target Duration: The Steering Committee discussed whether the target should be established for a single year or multiple years and whether the target should change over time or be fixed.

- The Steering Committee favored setting a multi-year target so that performance could be evaluated before adjusting the target.
- Setting a four-year target would allow for two years of performance data to be available for consideration of a target during the fifth year.
- **Decision:** Set a stable four-year target.

Periodic Review of Target and Performance: The Steering Committee agreed that the target methodology and performance should be evaluated periodically. Members also agreed that there should be a trigger to re-visit the methodology and performance should there be a major change in the economy.

- **Decision:** Should there be a change in the economy, the target methodology will be re-visited. In addition, if a special factor such as the introduction of a new drug like Sovaldi impact spending, that factor should be evaluated when considering performance against the target.

Other Discussion:

- A Steering Committee member expressed concern about the relationship between the cost growth target and the OHIC ACO budget growth cap.
- A Steering Committee member noted that establishing a cost growth target would not disrupt the market. Another cautioned that the cost growth target could lock in existing inequities in pricing/performance.

Cost Growth Target: Reporting Performance

Timeline: Based on the Steering Committee's recommendations for setting the target, implementation will be as follows: 2019 will be Performance Year 1; 2020 data will be collected and analyzed for Year 1; in 2020 the State will begin discussion of setting the target for Year 5.

Reporting Performance: The Steering Committee discussed its goals for reporting performance. Some Steering Committee members noted that the authority and governance decision and the data source decision could influence their reporting recommendations. Some members noted the importance of being confident in vetting the accuracy of data before reporting it publicly. Steering Committee members agreed that the goal is transparency.

- **Decision:** Performance will be reported with responsible transparency.

Public Comment: Pano Yeracaris supported using patient-level data from the APCD data to inform care improvement.

Next Steps and Wrap-Up: The next Steering Committee meeting will take place on 11/26 from 9am-12pm at 301 Metro Center Blvd, Suite 203 in Warwick. The Steering Committee will focus discussion on authority and governance, cost growth target communication and implementation planning, and reactions to the 11/14 data use conference, *Leveraging Multi-Payer Claims Databases for Value,* if time allows.