Leveraging HealthFacts RI for Value: Analysis and Recommendations

STAKEHOLDER MEETING

PROVIDENCE, RHODE ISLAND

MAY 14, 2019

Acknowledgement

The Peterson Center on Healthcare is providing support for this project through June 30, 2019.

The Peterson Center on Healthcare was established by the Peter G. Peterson Foundation to transform US healthcare into a high-performance system by finding innovative solutions that improve quality and lower costs and accelerating their adoption on a national scale.

Welcome

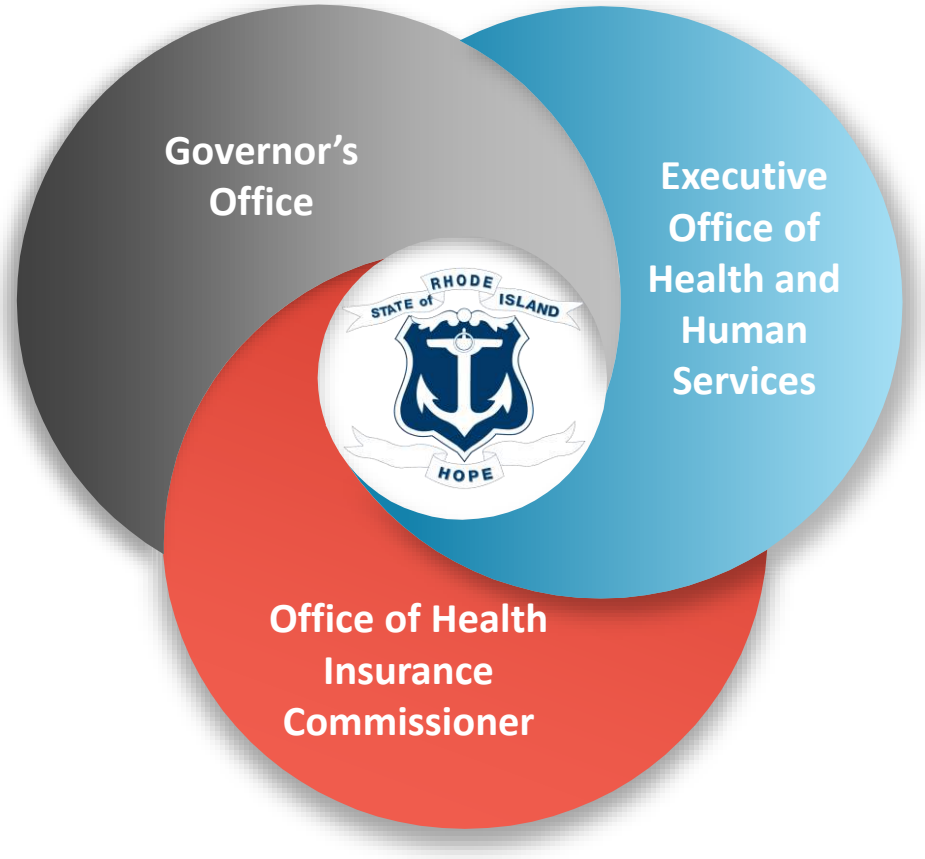
Meeting Agenda

1. Overview of the Rhode Island Health Care Cost Trends Project
2. Analysis of HealthFacts RI Claim Data
3. Washington Health Alliance Experience with Claims Data Analysis and Reporting
4. Proposed APCD Data Use Strategy
5. Next Steps and Wrap-up

Cost Trends Project Overview

Vision

To provide Rhode Island citizens with high-quality, affordable health care through greater transparency of health care performance and increased accountability by key stakeholders



Health Care Cost Trends Project: Overview

Goals:

1. To reduce growth in health care costs by developing a cost growth target and providing transparent health care performance data to influence purchasing decisions and care delivery reforms
2. To develop a deeper understanding of the state's health care cost drivers and cost variation
3. To create a sustainability plan to support ongoing analyses

A Steering Committee of payers, providers, and other business and community representatives is advising the State on this work.

Cost Trends Steering Committee

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

Health Care Cost Trends Project: Three Work Streams

The methodology for a health care cost growth target was to be developed for operationalization in 2019. *This work was completed in December 2018.*

Brown University was to conduct a data analysis to measure health care system cost performance and identify cost drivers. *We will share some of the findings today.*

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. *You will review the draft strategy today.*

Cost Growth Target

Established by Steering Committee member compact in December, and supported by Governor Raimondo's Executive Order in February.

Sets a state per capita cost growth target of 3.2% annually for 2019-2022.

Data will be calculated and reported from Medicare, Medicaid and all major insurers to assess performance at the state, insurance market, insurer and large provider levels.

Performance for 2019 to be reported in the fall of 2020.

Cost Growth Target

Compact Signing - December 19, 2018

Executive Order Signing - February 6, 2019

All-Payer Claims Database (APCD) Analyses

BACKGROUND, COST TRENDS, AND OTHER ANALYSES

NOT FOR CITATION

Agenda: APCD Data Analysis

1. Purpose of analyses
2. APCD basics
3. Missing data
4. Cost categories
5. Rhode Island health care costs (in national context)
6. Deconstructing costs and cost trends
7. Low-value care
8. High opportunity care episode: knee replacement
9. Volume vs. price
10. Provider groups in 2017
11. Conclusions

1. Purpose of Analyses

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3. Test the APCD as a data source for related analyses that could support cost growth reductions and eventually quality improvement: the APCD is a rich source of data for such analyses

2. APCD Basics

Payer Classifications

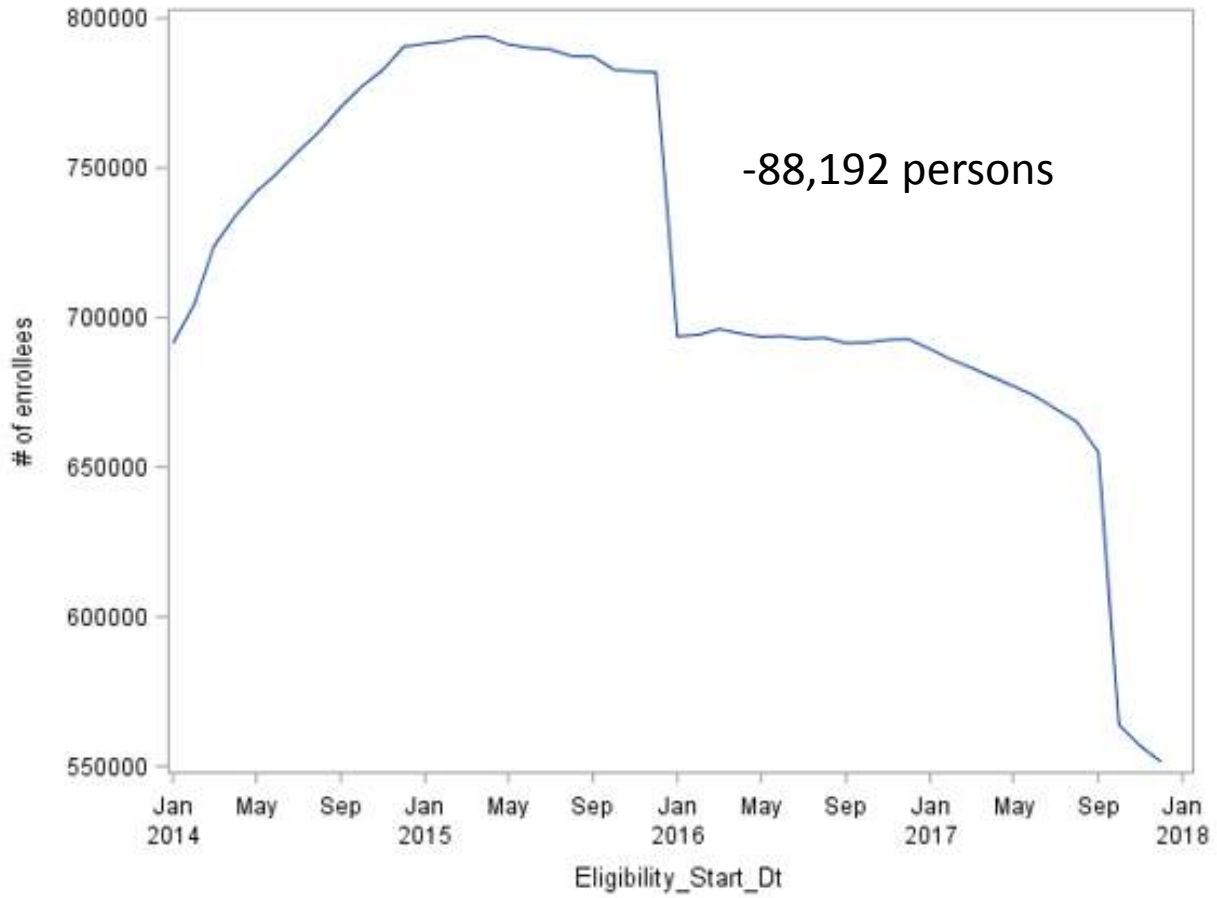
- Commercial (Fully Insured and Self-Insured)
- Medicare Fee-for-Service (FFS)
- Medicare Advantage (including Medicare Advantage + Medicaid)
- Dual Eligibles (those with Medicare + Medicaid)
- Medicaid Managed Care
- Medicaid FFS (note, very few in RI currently)

APCD Population (2014-2017)

Total unique persons	1,184,991
At least 1m enrolled	1,144,224 (96.6%)
Exclude minor plans	1,079,781 (91.1%)
At least 1m RI resident	1,039,435 (87.7%)
Total enrolled months 12+	932,642 (78.7)
Continuously enrolled 12m	923,246 (77.9)

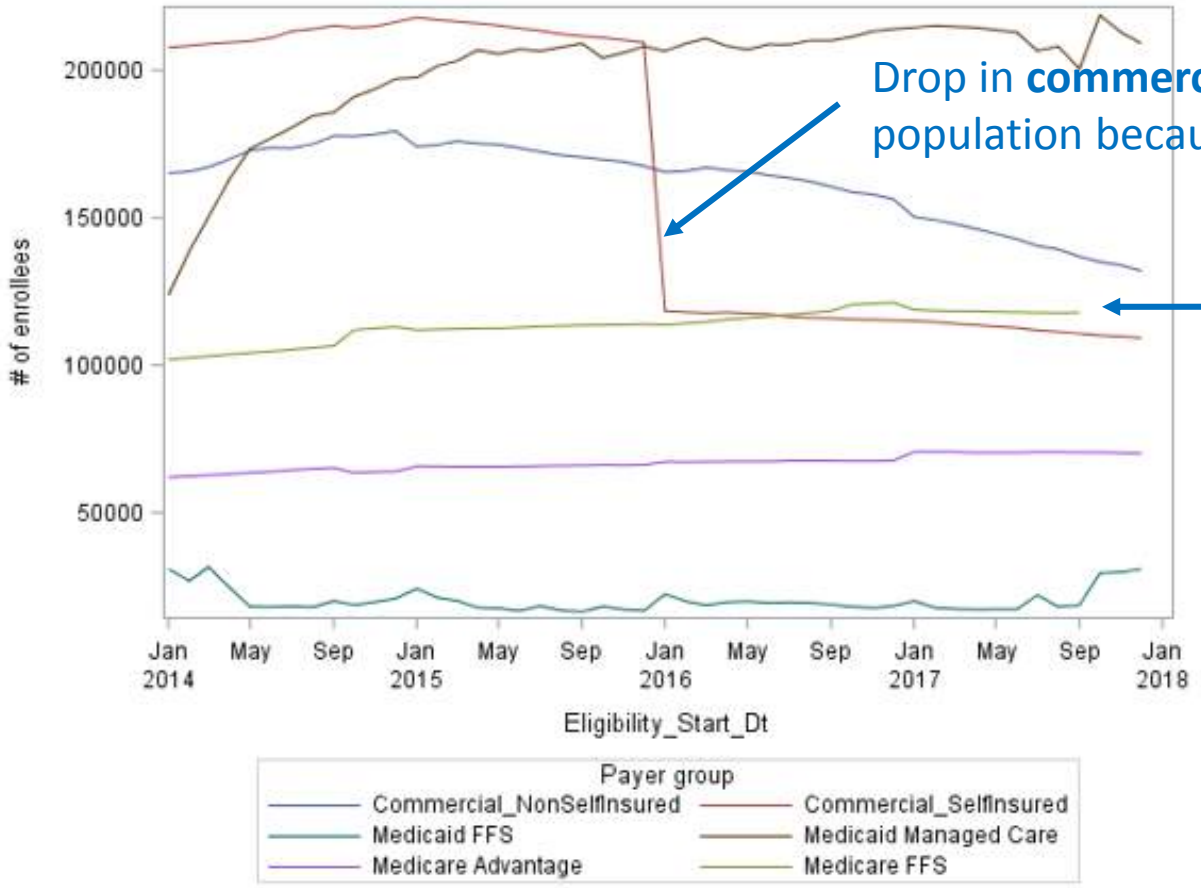
Total RI Population in 2017: 1.056M

APCD Basics: Total Enrolled



Supreme Court decision, *Gobeille v Liberty Mutual* (March 1, 2016): held (6-2) that the Employee Retirement Income Security Act (ERISA) invalidates state all-payer claims database (APCD) reporting requirements for self-funded employee health plans

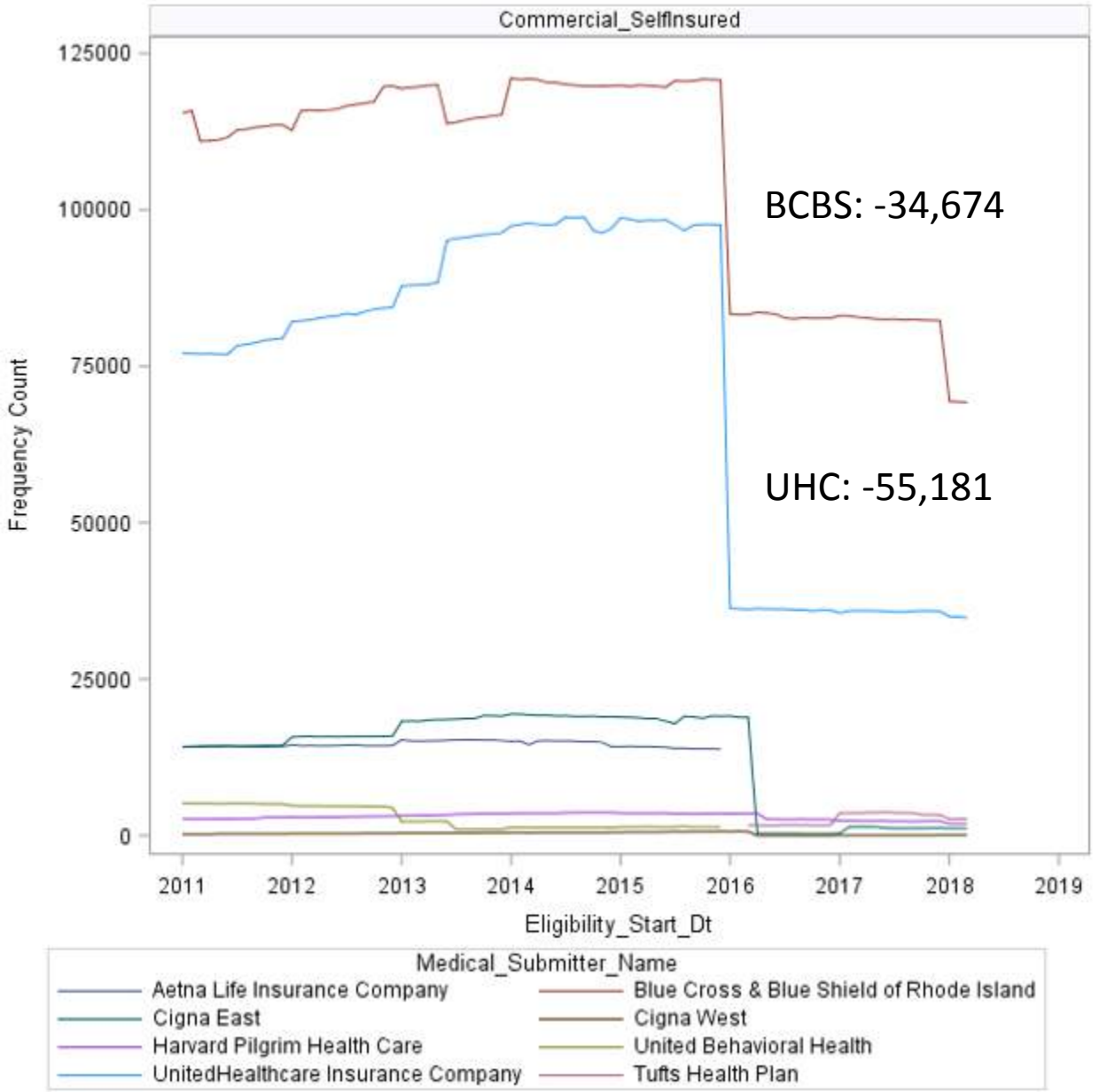
Total Enrolled by Payer Type



Drop in **commercial self-insured** population because of *Gobeille* decision

No Medicare FFS data for third quarter of 2017

Commercial, Self-Insured, by individual insurer



3. Missing Data

APCD: Structurally Missing Data

- Non-claims payments
  - Incentive payments (e.g., PCMH, ACO-related)
  - Carve outs (e.g., behavioral health, pharmacy)
- Self-insured data (per *Gobeille* decision)
- Our analyses have identified some other missing data: this is in the process of being corrected

Non-Claims Payments

Non-Claims Payments

Payer	% Non-Claims	Pattern 2014-2017
BCBS	1.5% - 3.4%	Slow increase
United	2-3%	Stable
NHP	?	?
Tufts	3-5%	Slow increase

Missing Data: Self-Insured Population

2017 Data for Self-Insured Patients by Payer

	BCBS		United		Tufts	
Comparators	In	Out	In	Out	In	Out
Percent	88	12	55	45	14	86
Risk Score	1.50	1.24	n/a	n/a	1.51	1.62
TMC, PMPM	$376	$343	$453	$346	$464	$574
% Difference PMPM		**-9.6%**		**-30.9%**		**+19.2%**

TMC: total medical cost
PMPM: per member per month

Conclusions: Missing Data

- To date, the fraction of total costs that are non-claims-based payments is small, but as we have discussed, this percentage is likely to increase over time
- "Included" self-insured patients compared to "non-included" self-insured patients differ substantially, which is clearly a problem if we want to look at valid cost trends
- Until these different types of missing data can be included in the APCD (2-4 years), the APCD should not be used to assess trends in total costs

4. Cost Categories

Health Care Cost Institute (HCCI)

- Replicated their methodology to the extent possible
- Their methodology is respected and very clearly explained in methods documents
- Allows direct comparisons between their national commercial data and RI commercial data

HCCI Cost Sub-Categories

- Inpatient
- Outpatient
- Professional Services
- Prescription Drugs

5. Rhode Island Health Care Costs

RHODE ISLAND HEALTH CARE COSTS IN NATIONAL CONTEXT

RI in National Context

WEB FIRST

By David Lassman, Andrea M. Sisko, Aaron Catlin, Mary Carol Barron, Joseph Benson, Gigi A. Cuckler, Micah Hartman, Anne B. Martin, and Lekha Whittle

Health Spending By State 1991–2014: Measuring Per Capita Spending By Payers And Programs

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NO. 7 (2017): 1318–1327

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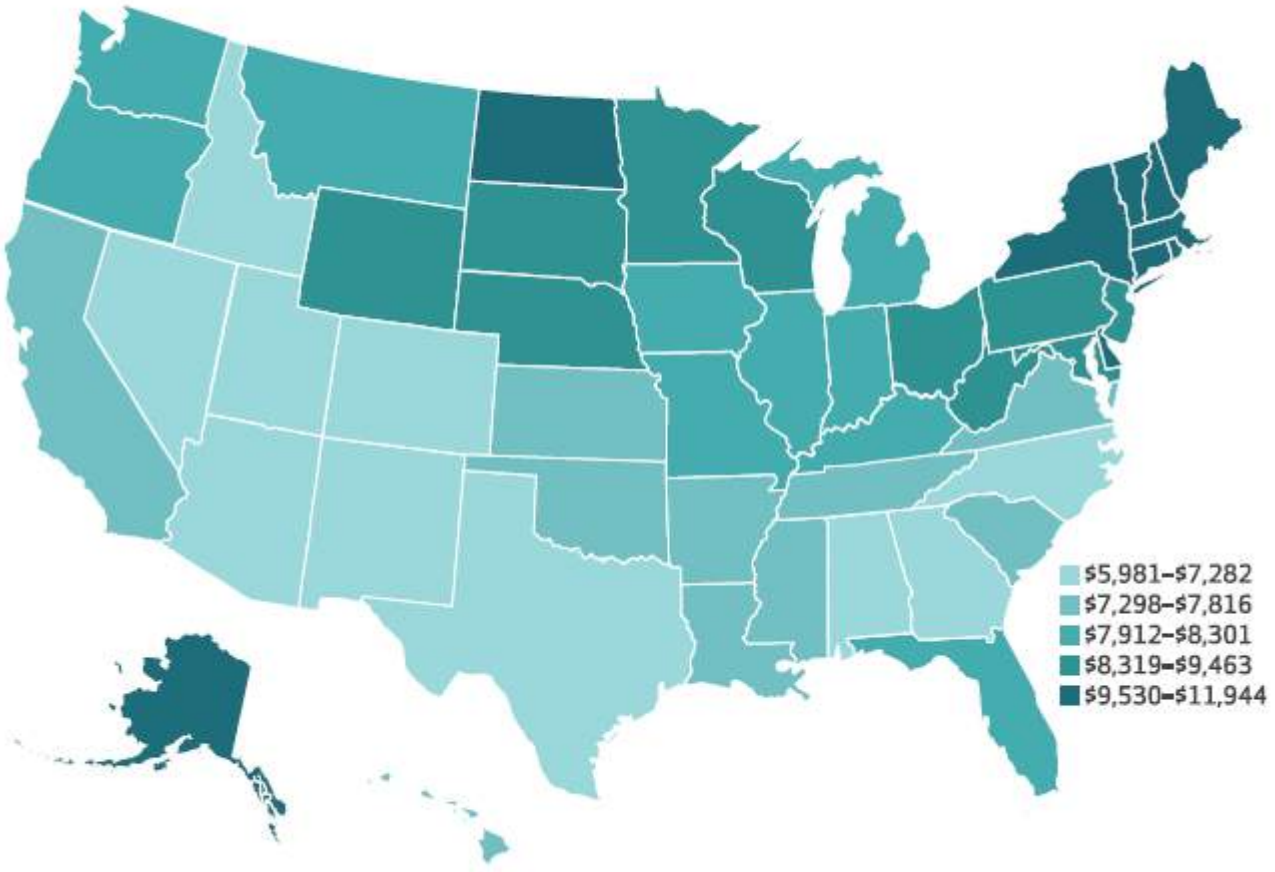
Mary Carol Barron is an economist in the CMS Office of the Actuary.

Joseph Benson is an

ABSTRACT As the US health sector evolves and changes, it is informative to estimate and analyze health spending trends at the state level. These estimates, which provide information about consumption of health care by residents of a state, serve as a baseline for state and national-level policy discussions. This study examines per capita health spending by state of residence and per enrollee spending for the three largest payers (Medicare, Medicaid, and private health insurance) through 2014. Moreover, it discusses in detail the impacts of the Affordable Care Act implementation and the most recent economic recession and recovery on health spending at the state level. According to this analysis, these factors affected overall annual growth in state health spending and the payers and programs that paid for that care. They did not, however, substantially change state rankings based on per capita spending levels over the period.

EXHIBIT 2

Per capita personal health care spending by state of residence, calendar year 2014



SOURCES Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group; and Census Bureau.

New England is the highest cost region in the US

EXHIBIT 1

Per capita personal health care spending and average annual changes in selected time periods, by region and state of residence, 2004–14

		Personal health care spending			Average annual change		
Region	**State**	**2009**	**2013**	**2014**	**2004–9**	**2010–13**	**2014**
United States		$ 6,892	$ 7,703	$ 8,045	5.2%	2.8%	4.4%
New England	Connecticut	8,740	9,517	9,859	5.8	2.2	3.6
	Maine	8,359	9,133	9,531	5.4	2.2	4.4
	Massachusetts	9,417	10,273	10,559	6.1	2.2	2.8
	New Hampshire	8,134	9,369	9,589	7.6	3.6	2.4
→	Rhode Island	8,393	9,160	9,551	5.7	2.2	4.3
	Vermont	8,111	9,919	10,190	5.9	5.2	2.7

Compared with other NE states, RI is consistently one of the lowest spending states, but *compared with the rest of the country*, RI is clearly one of the higher spending states.

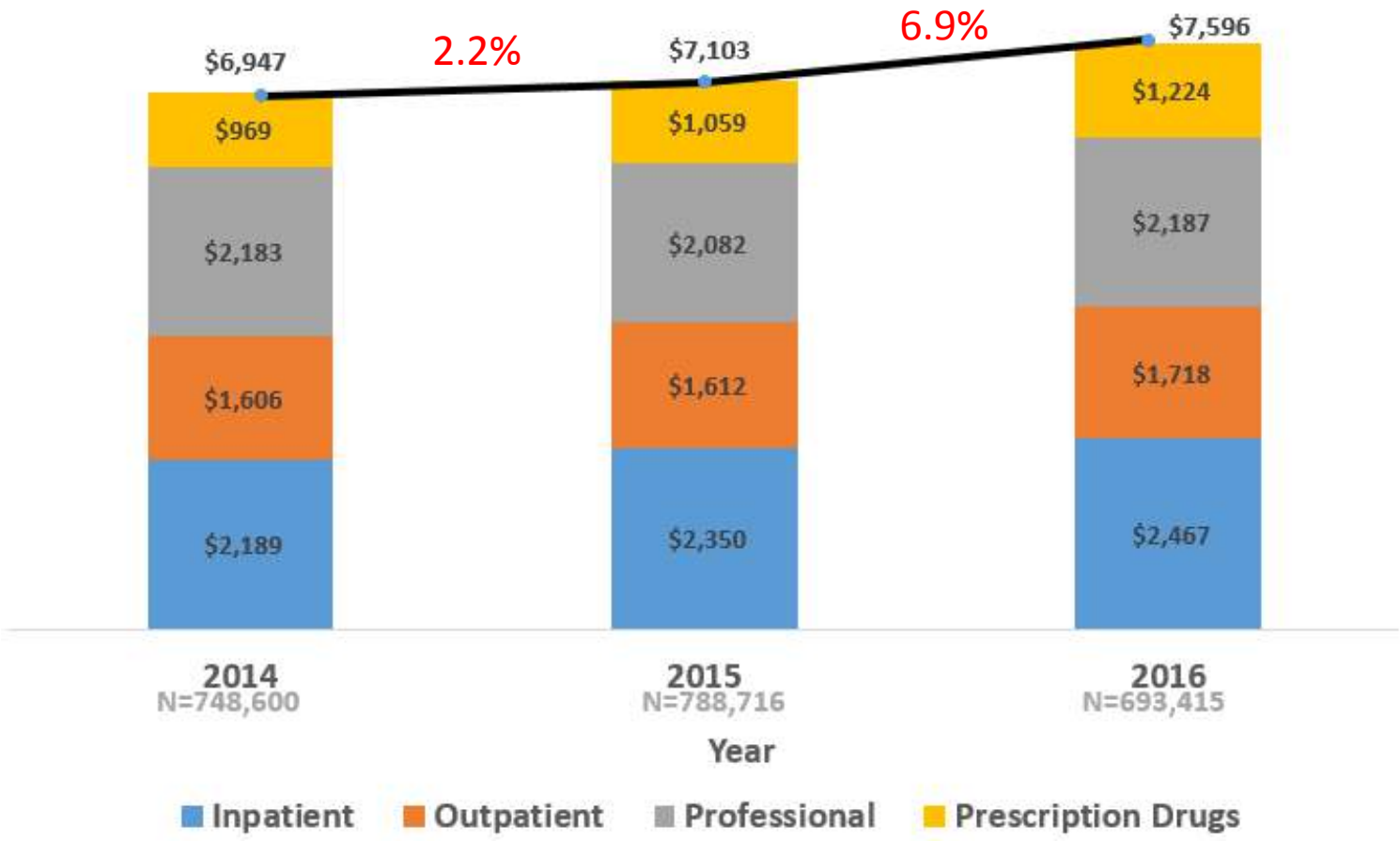
6. Deconstructing Costs and Cost Trends

NOT FOR CITATION. THE PURPOSE OF THIS EXERCISE IS TO DEMONSTRATE HOW THESE DATA CAN BE PRODUCTIVELY USED.

Cost Trends vs. Cost Drivers

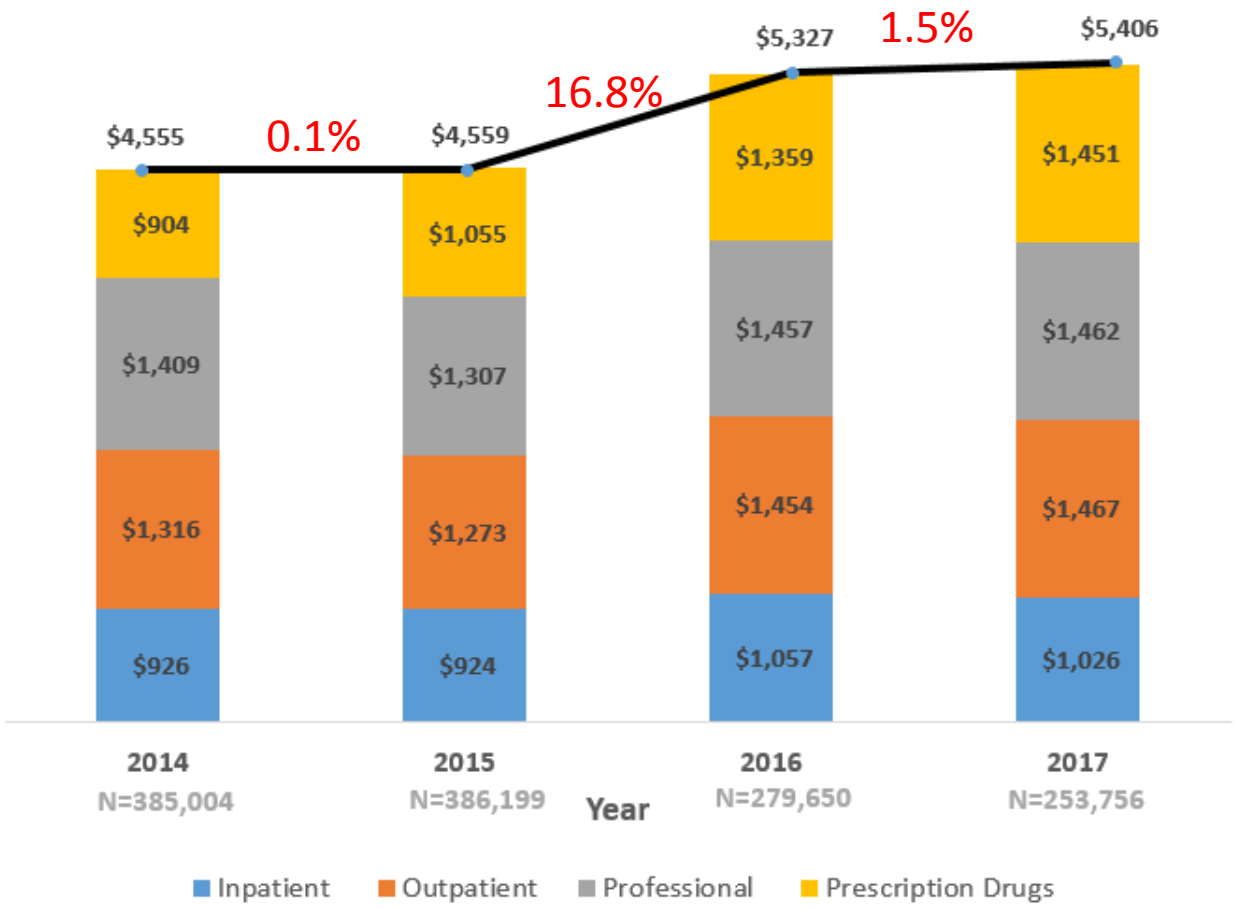
- While imperfect at the moment for measuring total costs and cost trends, APCD data are critical to the understanding of ***drivers of cost*** and ***drivers of cost trends***
- Drivers of costs and drivers of cost trends cannot be understood at the state level without multi-payer data
- What follows are demonstrations of the value of APCD data in understanding these drivers for commercial insurance

Annual Cost Trends, All Payers, PMPY



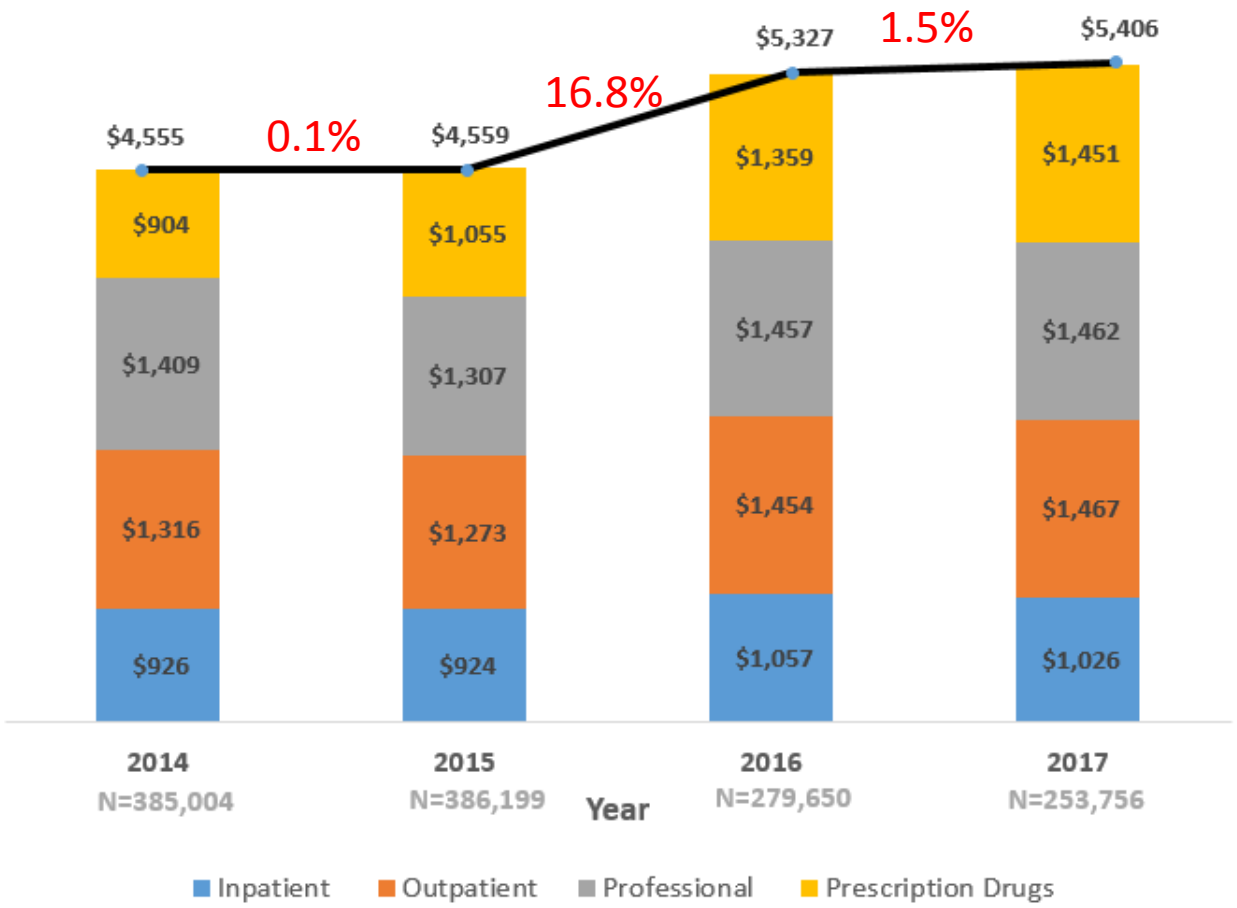
Note that there are 95,301 fewer patients in 2016 than 2015. We do not include the 2017 data because the Medicare FFS 4th quarter data has just arrived.

Annual Cost Trends, Commercial, PMPY



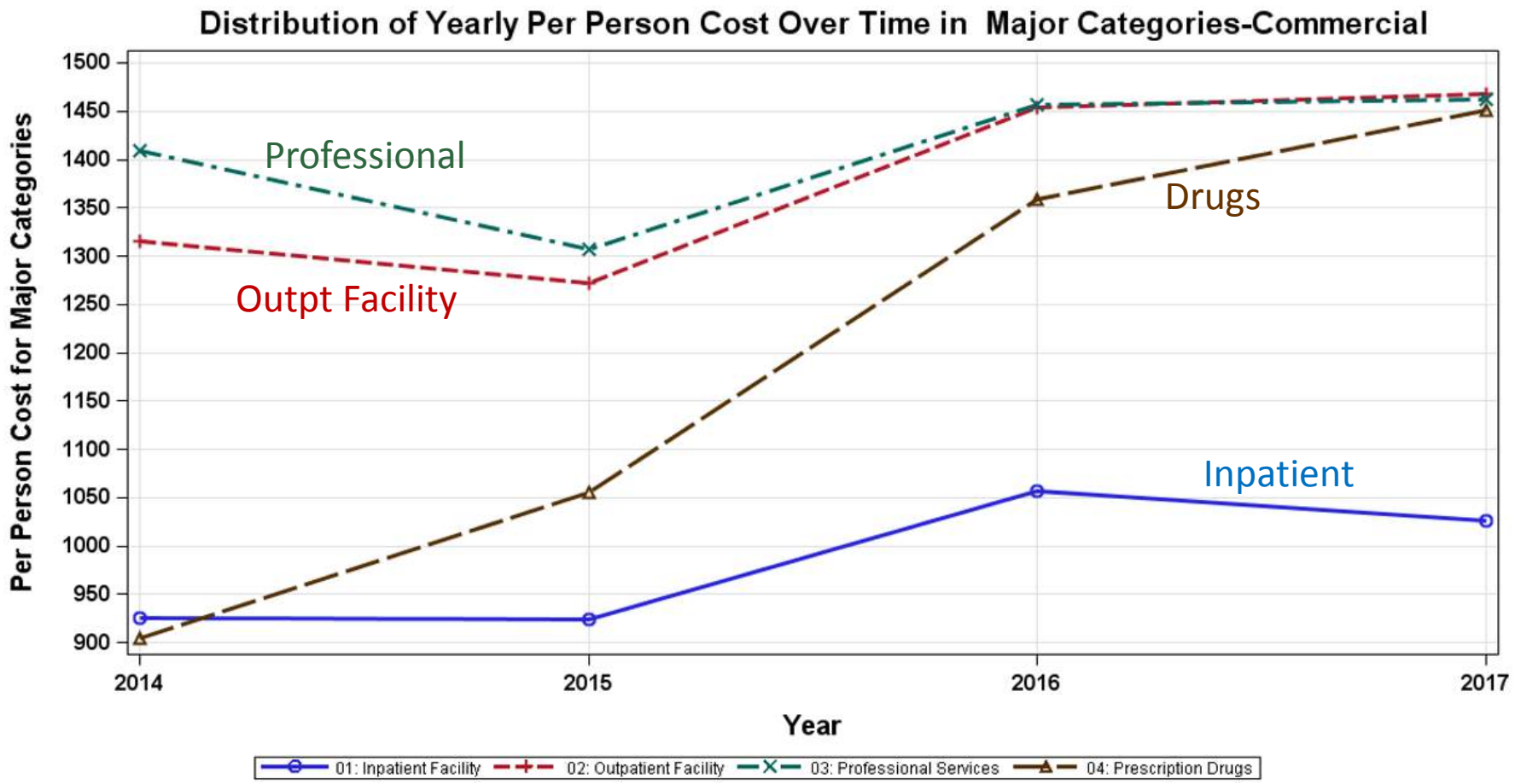
We know that data problems caused the 2015 cost data to be too low (being fixed). Again note that there are over 100K fewer patients in 2015 than 2016.

Annual Cost Trends, Commercial, PMPY



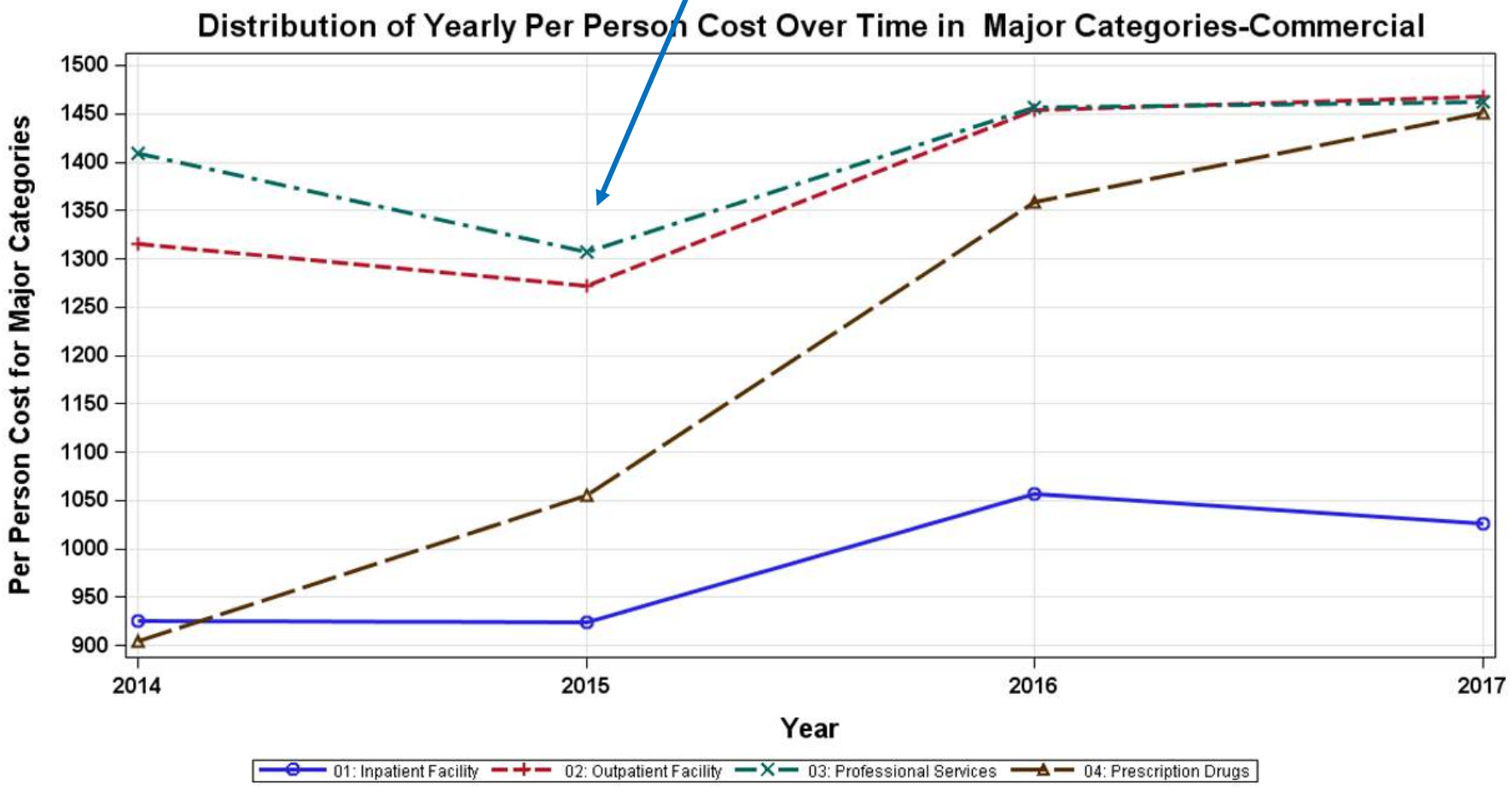
Notwithstanding these data issues, what can these data tell us about drivers of cost and cost trends?

Cost Category Trends, Commercial



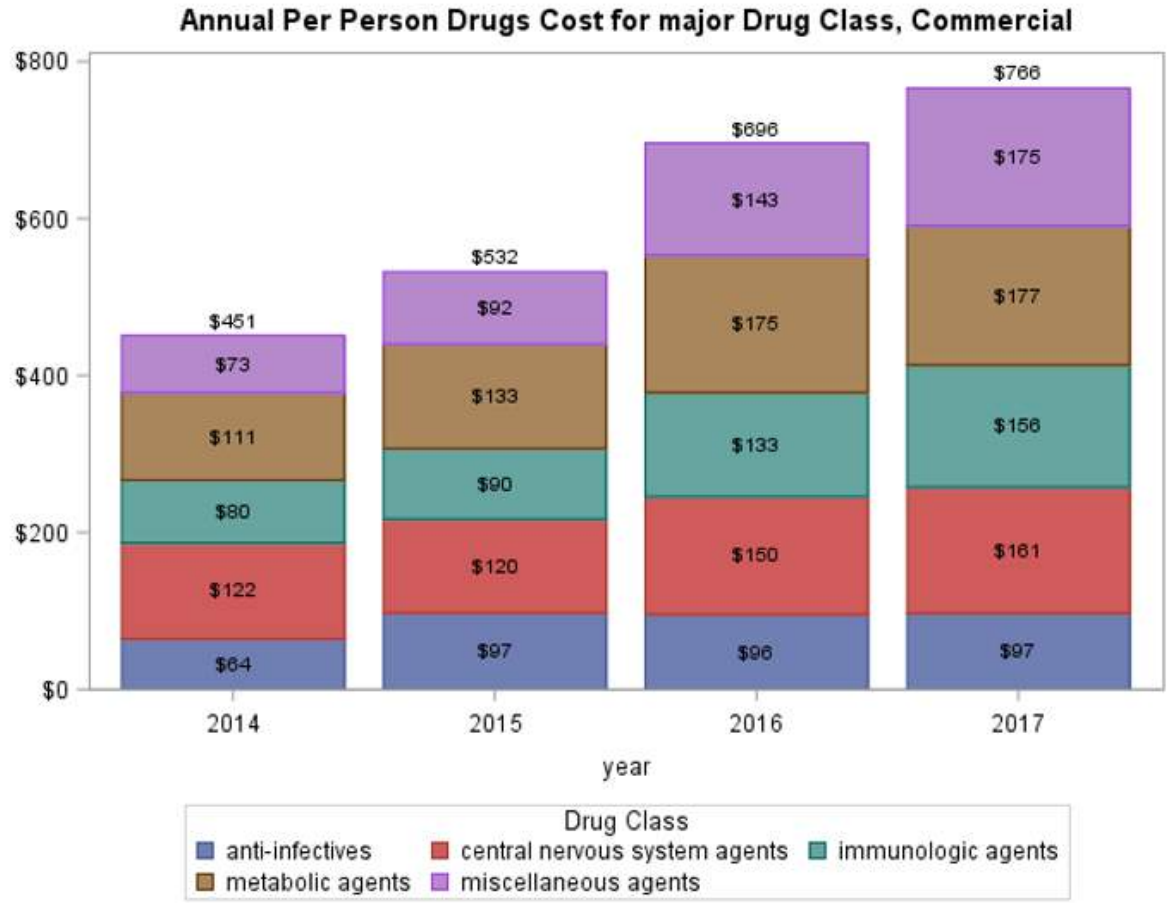
We know these are artificially low (missing data).

Cost Category Trends, Commercial

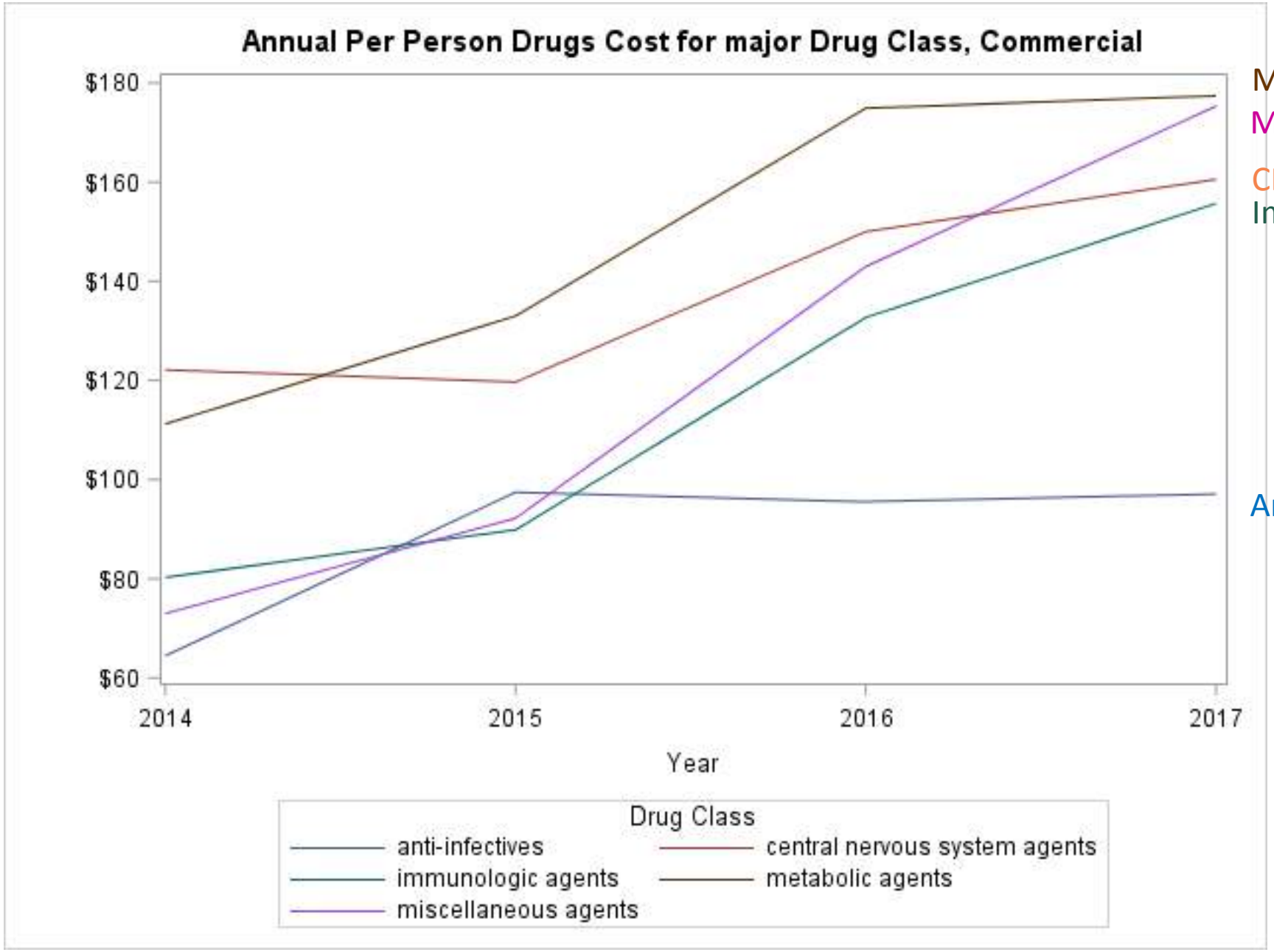


Drugs show 36% increase in 3 years. Clearly drugs are drivers of both ***total costs*** and ***cost trends*** for commercially insured.

What are the Drivers of Drug Costs?



Drugs can of course be further broken down into different classes.



Metabolic Agents

Miscellaneous

CNS Agents

Immunologic Agents

Anti-infectives

Generic name	Brand name	Indication
Anti-infective		
ledipasvir-sofosbuvir	Harvoni	Hepatitis C
efavirenz/emtricitabine/tenofovir	Atripla	HIV
emtricitabine-tenofovir	Truvada	HIV/HIV prevention
CNS agents		
amphetamine-dextroamphetamine	Adderall	ADHD
methylphenidate lisdexamfetamine	Vyvanse	ADHD
lisdexamfetamine	Vyvance	ADHD
Immunologic agents		
glatiramer	Copaxone	MS
dimethyl fumarate	Tecfidera	MS
fingolimod	Gilenya	MS
Metabolic agents		
insulin glargine	Many	Long acting insulin
rosuvastatin	Crestor	Cholesterol lowering
insulin lispro	Humalog	Short acting insulin
Miscellaneous		
adalimumab	Humira	Crohn's Dz, psoriasis
etanercept	Embrel	RA, psoriasis
inFLIXimab	Remicaid	RA, psoriasis

For each of these 5 drug classes, the three top individual drugs and their indications are listed.

Conclusions (Commercial)

- Main point here is not what the total cost trends are; we know that we are missing data needed to accurately describe these trends. Rather, these data can show a lot about ***drivers of cost*** and ***drivers of cost trends***
- Total PMPY inpatient, outpatient, and professional costs all increased over the 4-year period; but drug costs increased dramatically
- Note that 25-30% of drug costs are bundled into inpatient and professional costs, so we are not even seeing the full impact of drug costs here
- We have completed other similar analyses for other payers

7. Low-Value Care

Definition of Low-Value Care

- For each of the 16 low-value care measures, we identified “qualifying visits” at which patients were eligible to receive low-value services based on qualifying diagnoses and exclusions.
  - Denominator = Total qualifying visits
  - Numerator = Total visits that included a low value service

Definition of Low-Value Care

Example:

Numerator: Visits with a diagnosis of headache but no current diagnosis or one-year medical history of epilepsy that included an electroencephalogram service.

_____

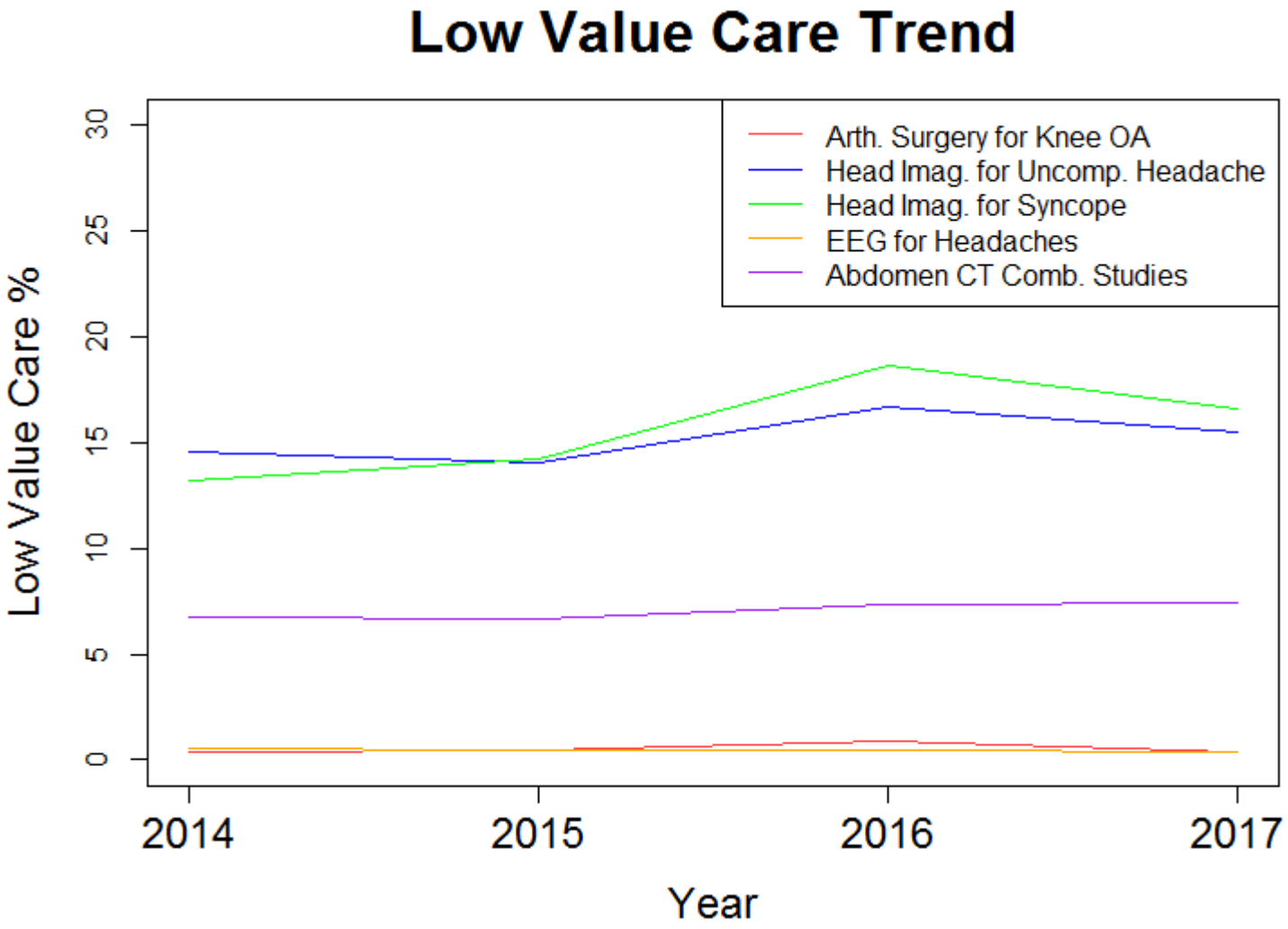
Denominator: Total visits with a diagnosis of headache but no current diagnosis or 1-year medical history of epilepsy.

Common Types of Low-Value Care

We have data on 16 different types of Low-Value Care. Examples include:

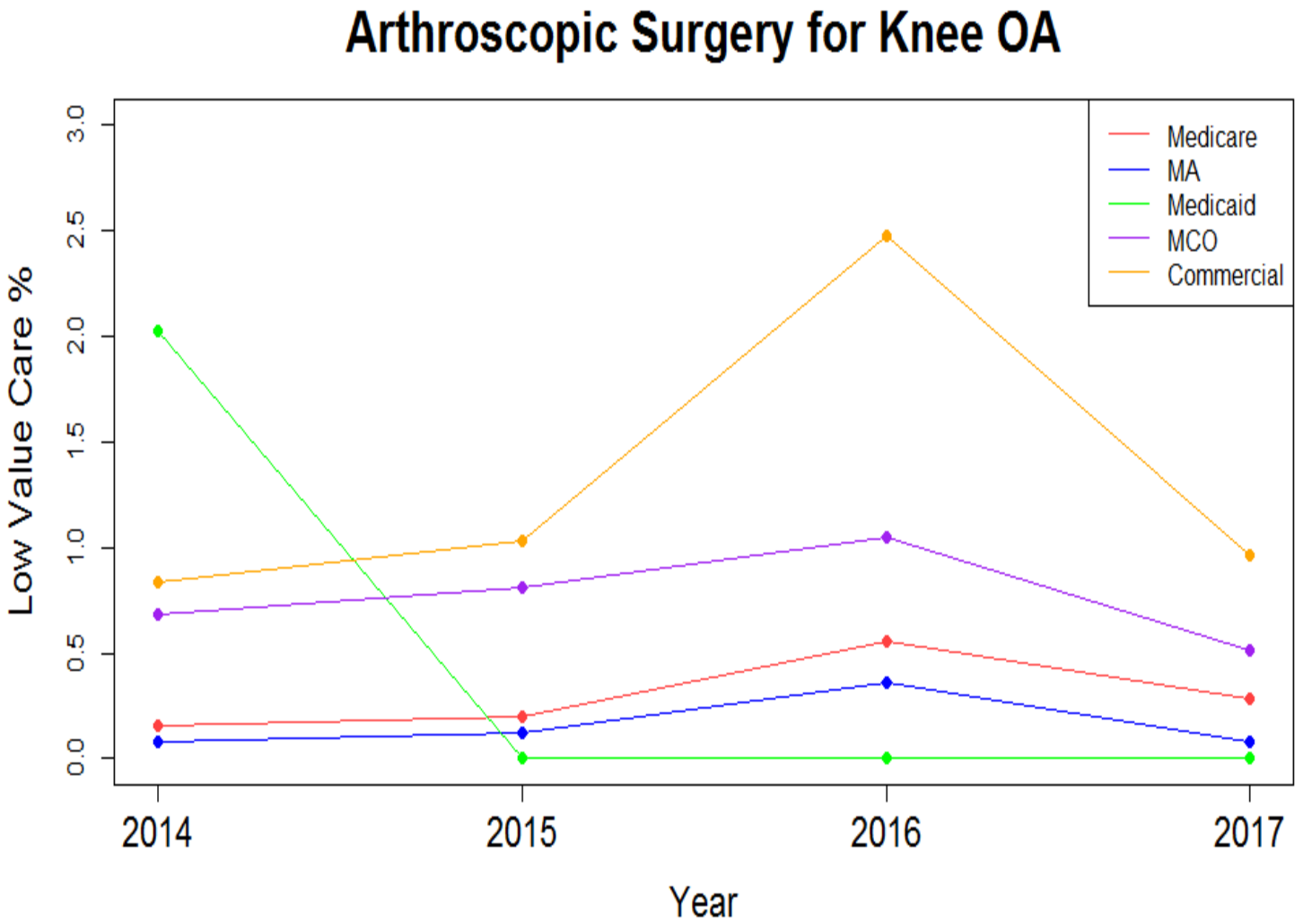
1. Arthroscopic surgery for knee osteoarthritis
2. Head imaging for uncomplicated headache
3. Head imaging for syncope
4. EEG for headaches
5. Abdominal CT combination studies (abdomen/pelvis)

Overall Trends (all Payers)



Levels of low-value care clearly vary from one measure to the next.

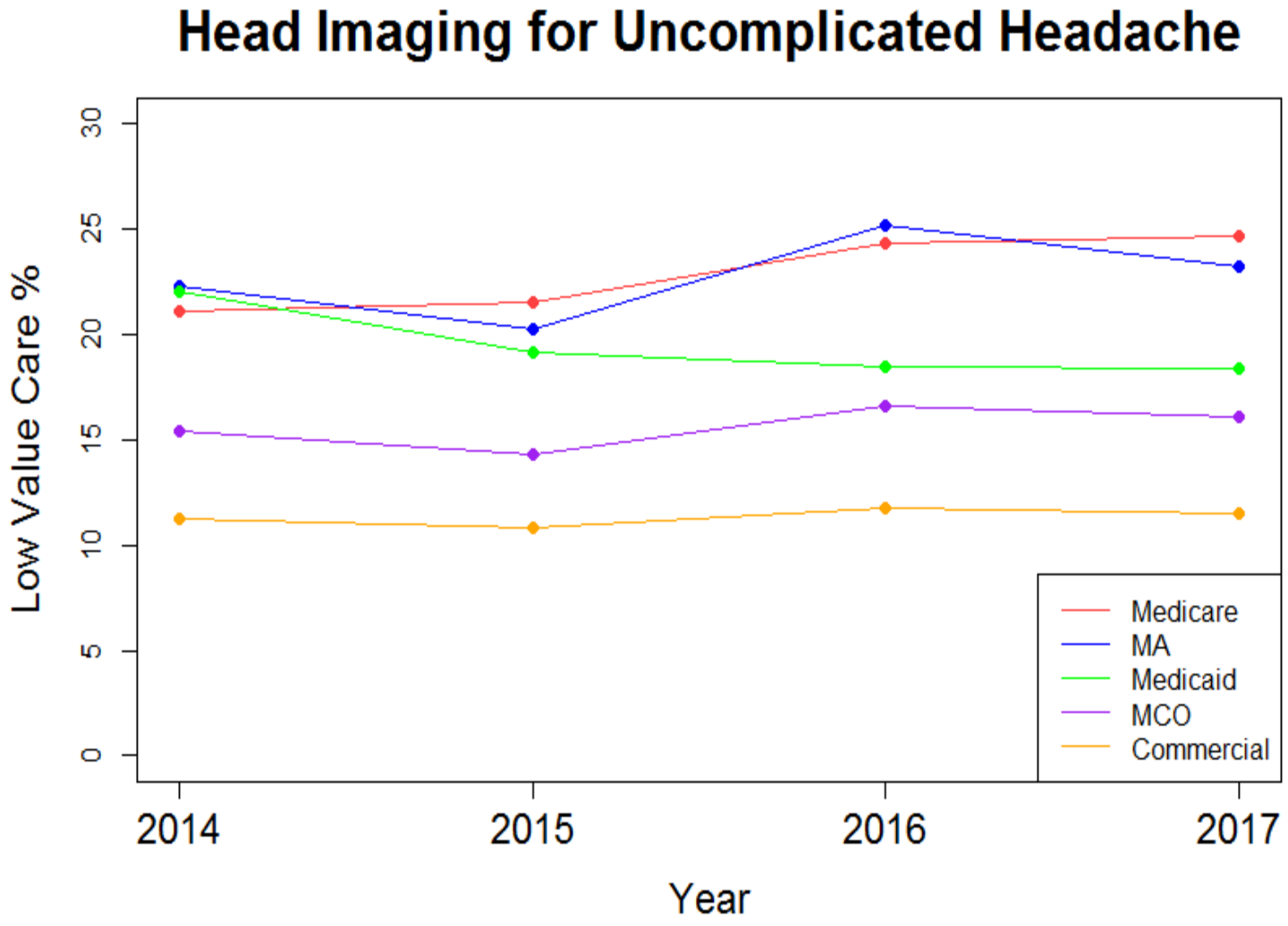
Trends for Individual Types of LVC, by Payer



Medicaid=Medicaid FFS
MCO=Medicaid MC

Even for a relatively low prevalence measure, there is 2-4 fold variation at the payer level.

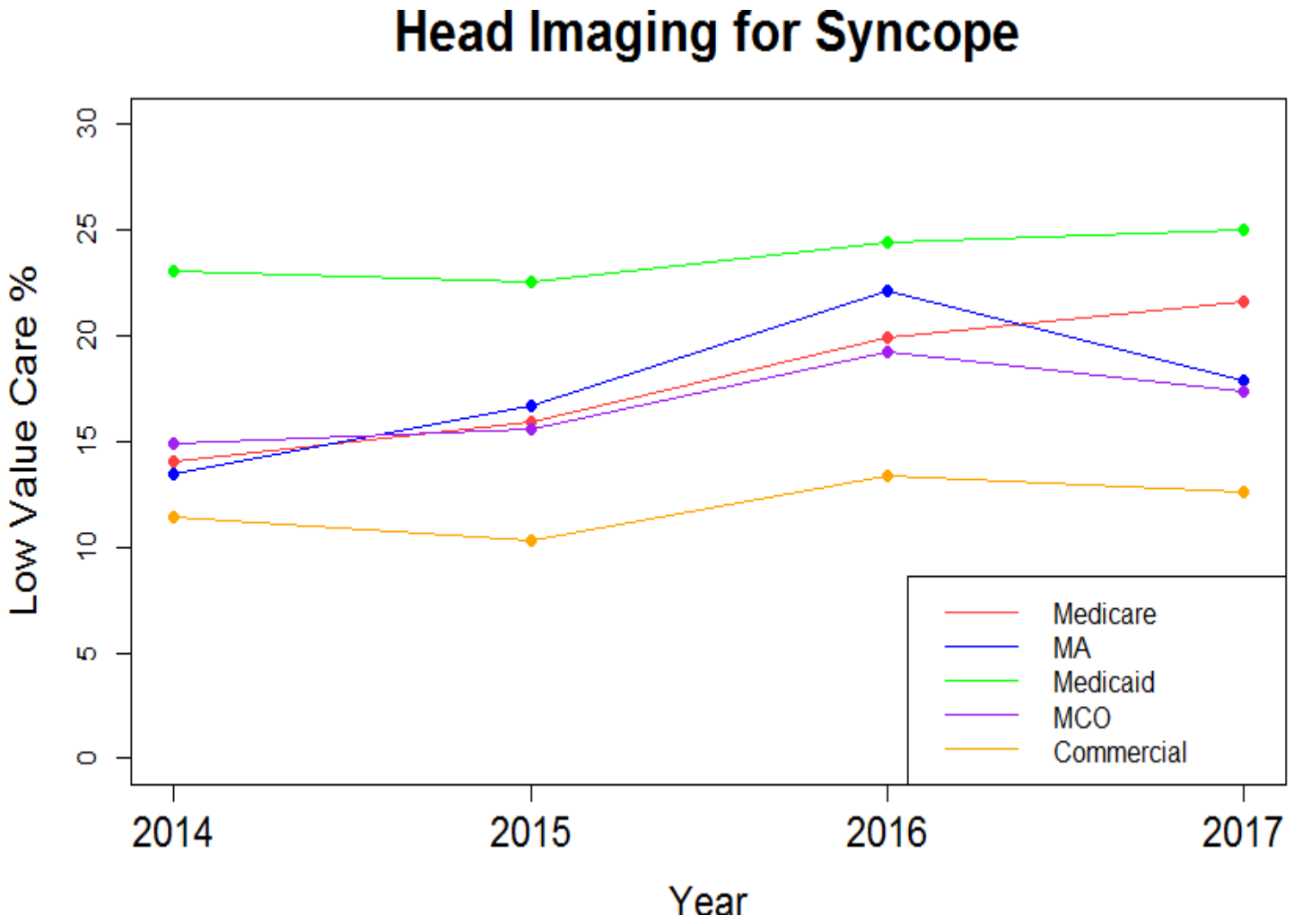
Trends for Individual Types of LVC, by Payer



Somewhat stable over time, but 2.5 fold variation across payers.

Medicaid=Medicaid FFS
MCO=Medicaid MC

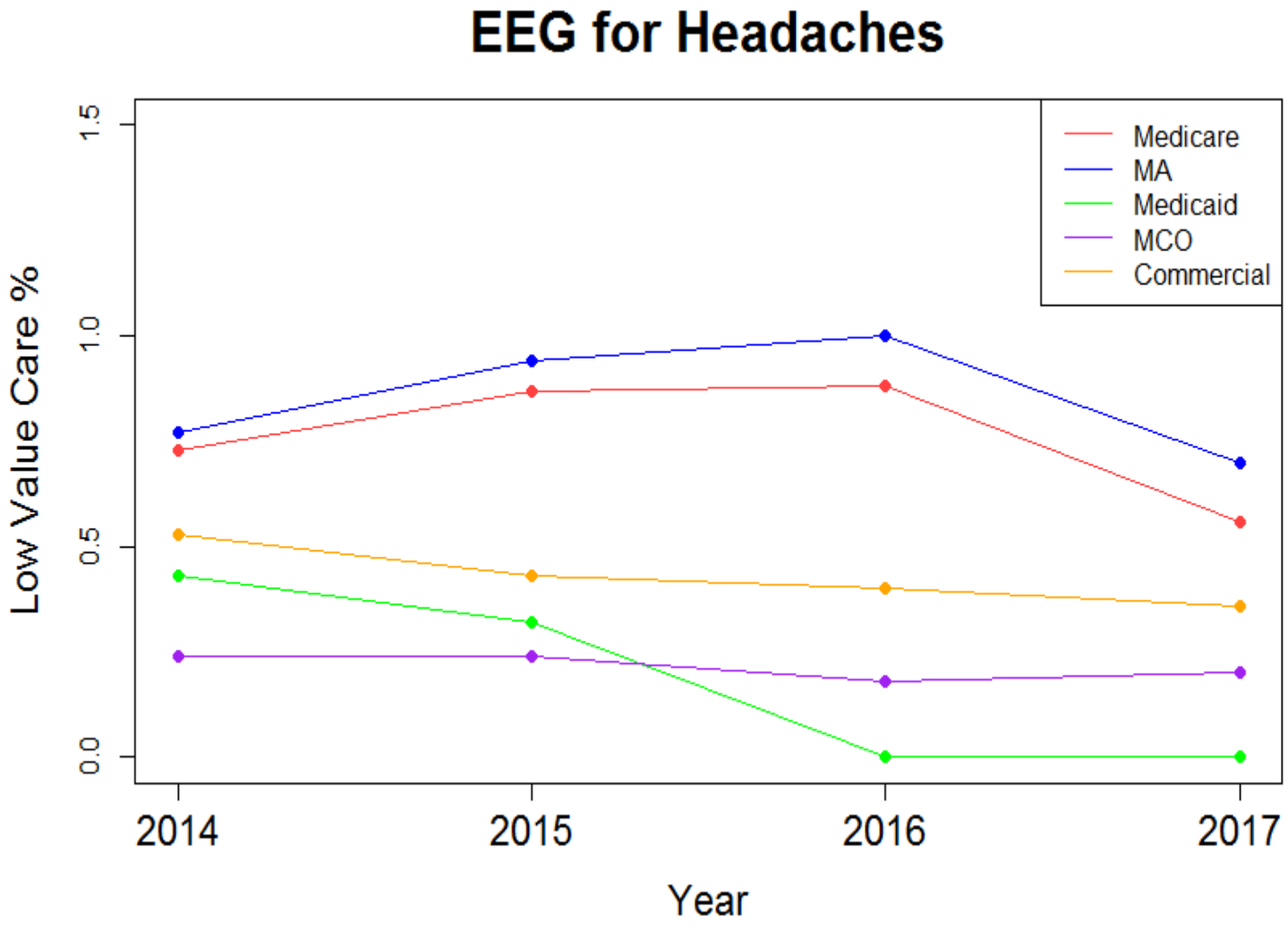
Trends for Individual Types of LVC, by Payer



Similar 2-2.5 fold variation, but with a different payer with the highest rate.

Medicaid=Medicaid FFS
MCO=Medicaid MC

Trends for Individual Types of LVC, by Payer



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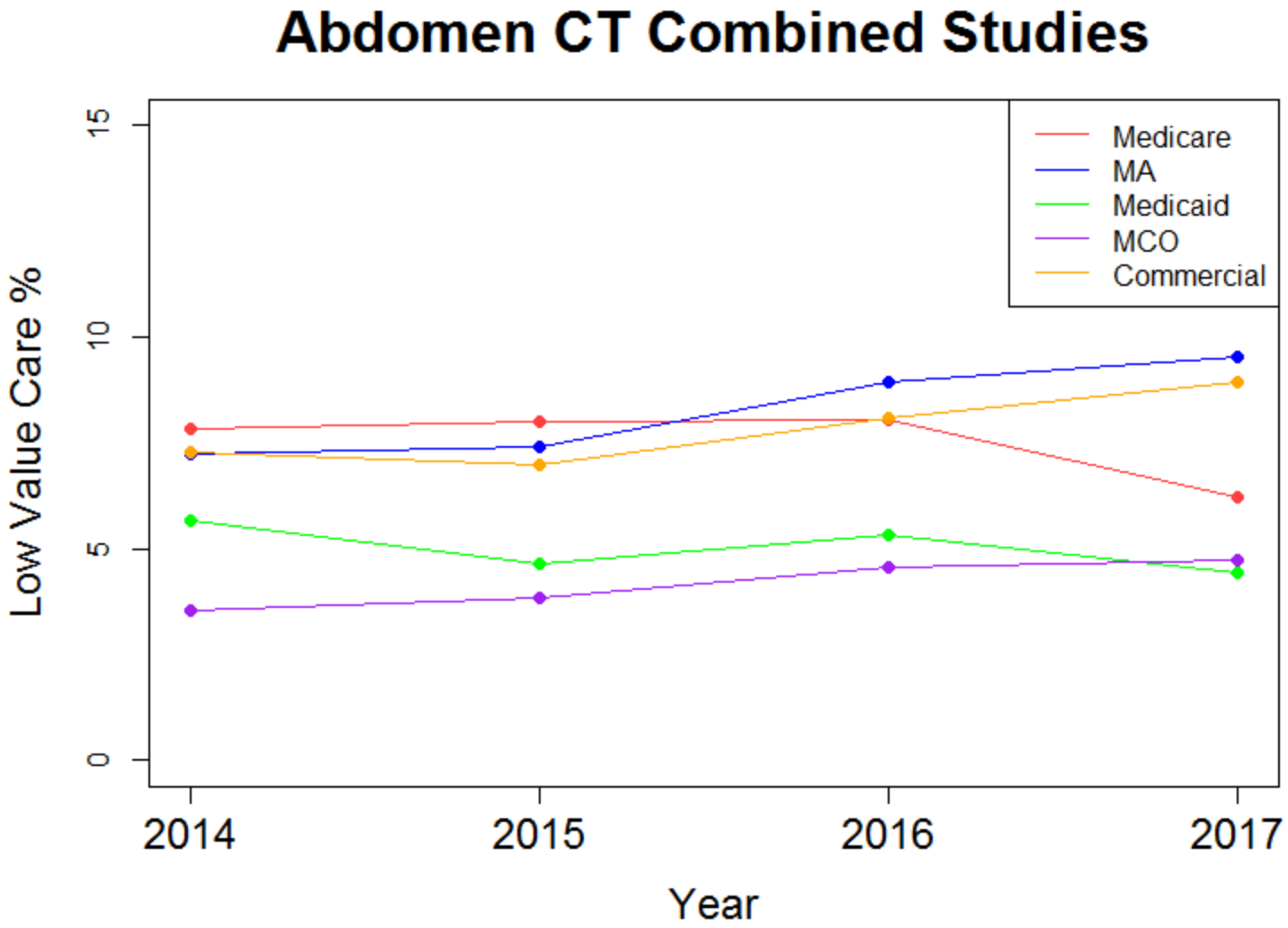
Three-fold variation by payer.

Trends for Individual Types of LVC, by Payer



Medicaid=Medicaid FFS
MCO=Medicaid MC

Two-fold variation by payer.

Conclusions: Low-Value Care

- Low-value care can be identified in RI APCD data.
- Rates and variations in rates are substantial.
- Tremendous opportunities to reduce unnecessary costs.

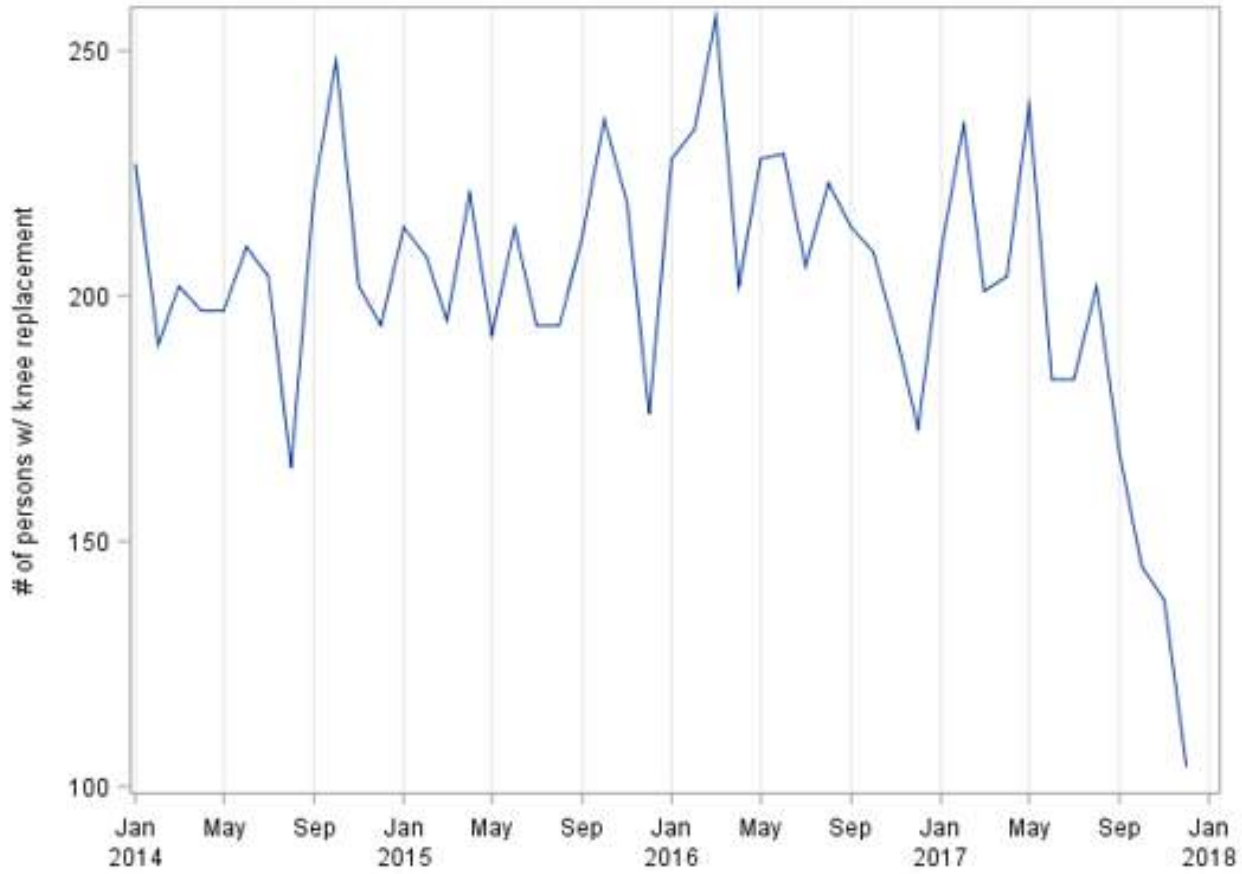
8. High Opportunity Care Episodes

KNEE REPLACEMENT

Total Knee Replacement (TKR) “Episodes”

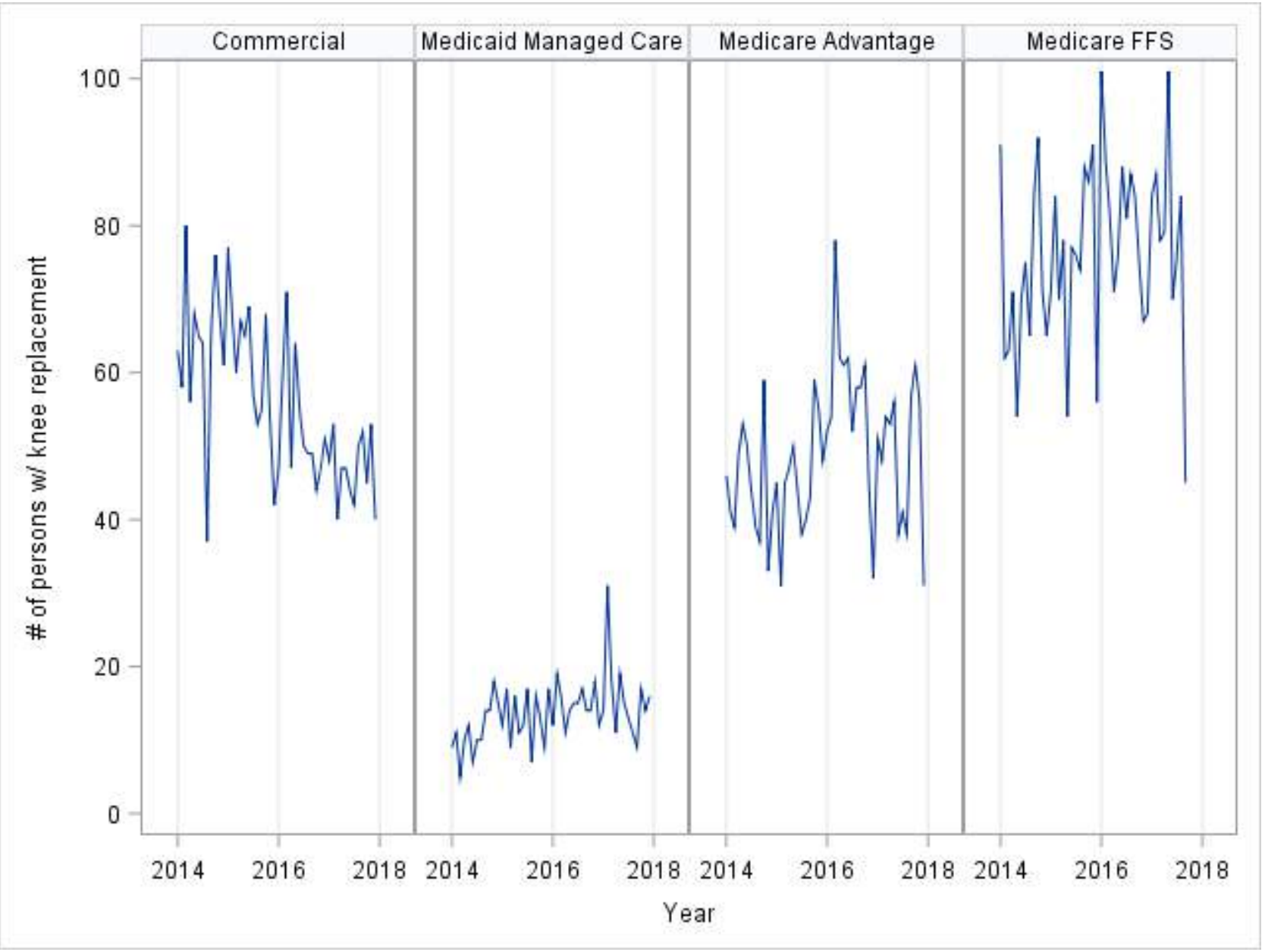
- In this case the “episode” includes all of the costs associated with the **hospitalization only**
- “Bundles” for orthopedic procedures can also include pre and post-operative care outside of the hospitalization for the surgery; we defined “episode” more narrowly for this analysis

Trends in # of persons with TKR, All Payers

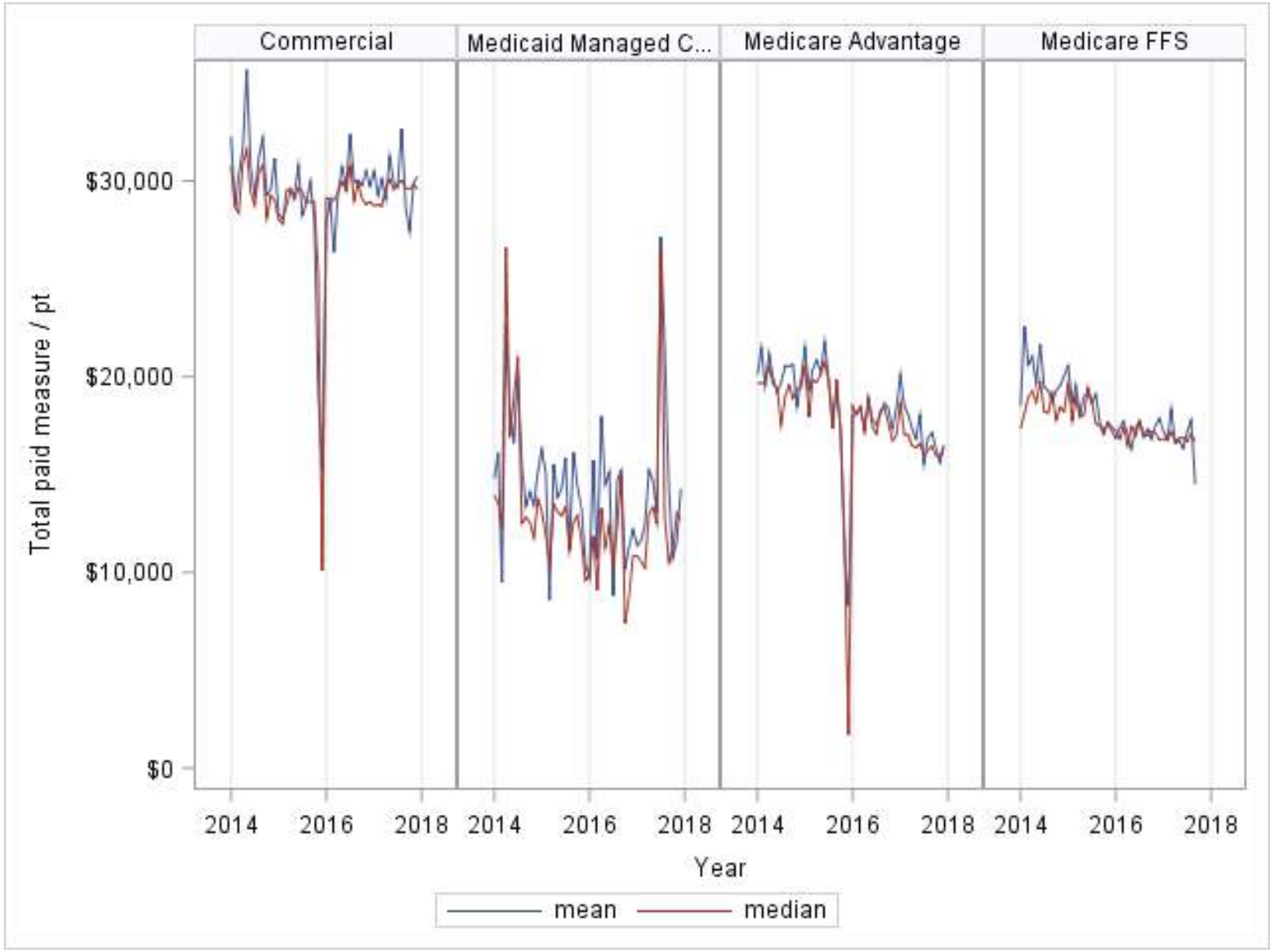


These analyses look at monthly rates, so you would expect to see this kind of month to month variation.

Fourth quarter 2017 drop is related to the fact that we are missing Medicare FFS data in this quarter.



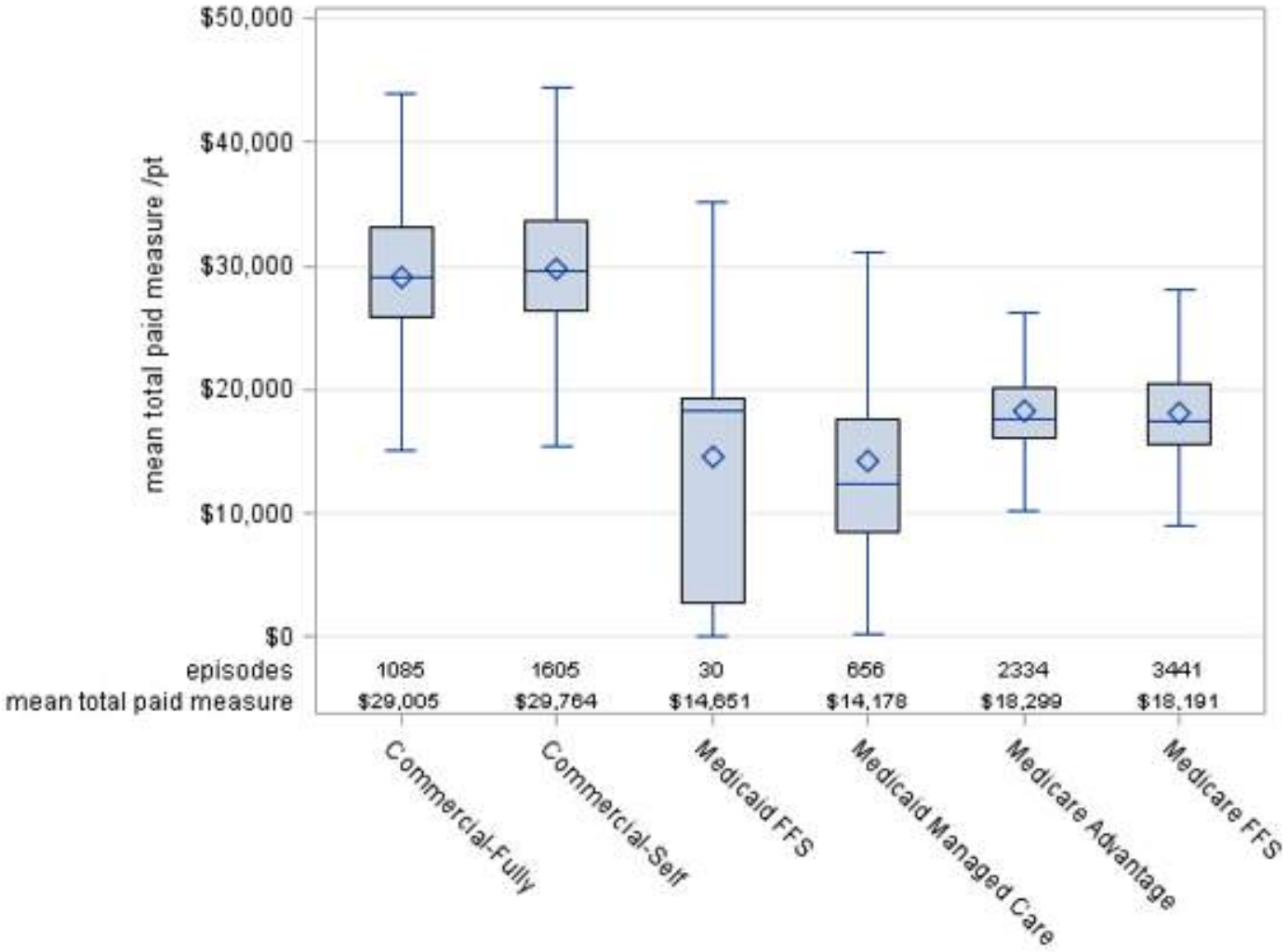
Trends in #s of persons with TKR, by payer. Note that there are no prominent upward trends.



Trends in total paid amounts for TKR per patient, by payer. Trends flat to downward, but note differences between payers.

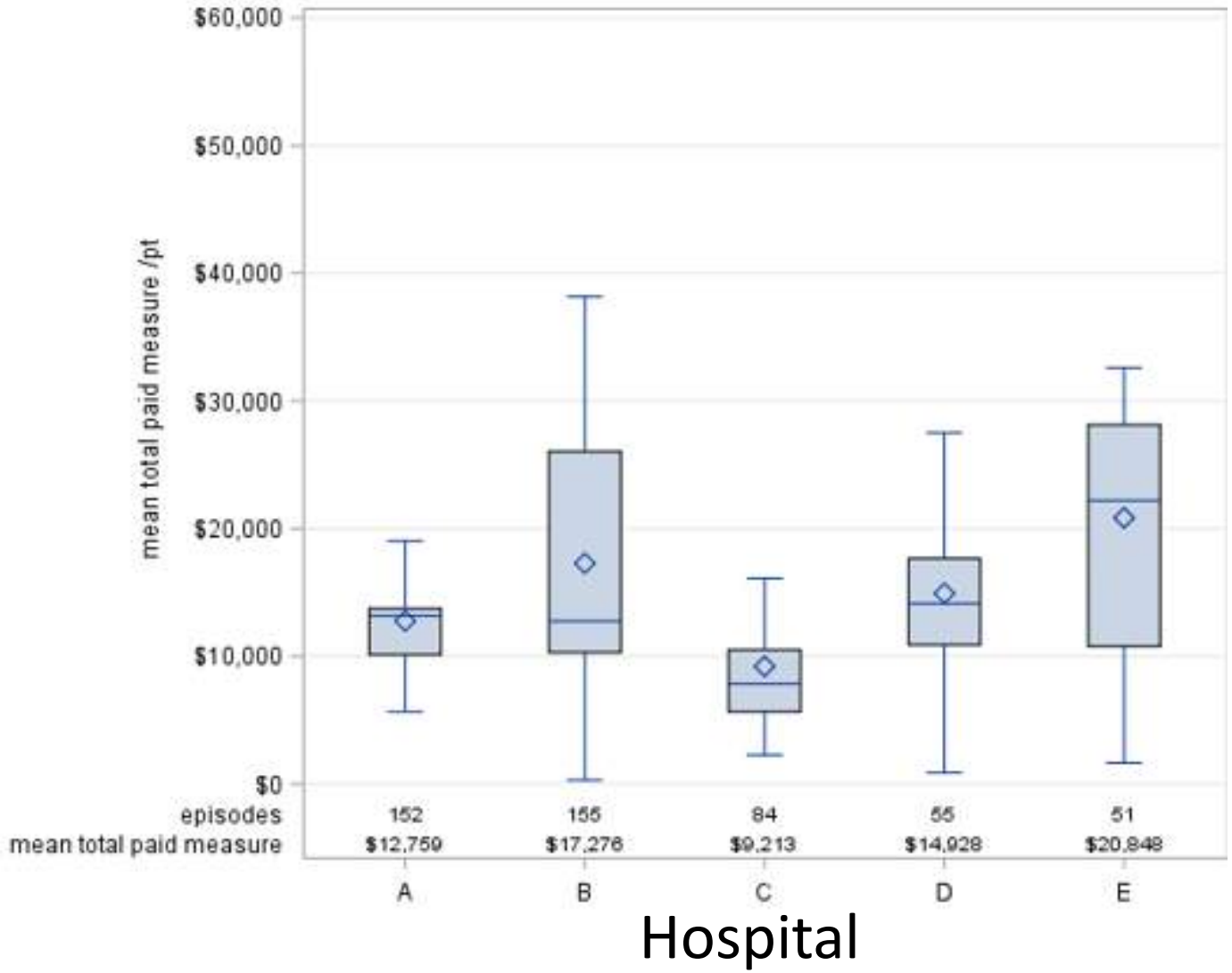
Again we see drop in last quarter of 2015 (BCBS missing data).

TKR Episode Costs by Payer



Clearly there is variation within payer groups.

Total episode cost, commercial payers, by hospital (labeled A, B, C, D, E)



Clearly there is cost variation at the hospital level for TKRs paid for by commercial payers.

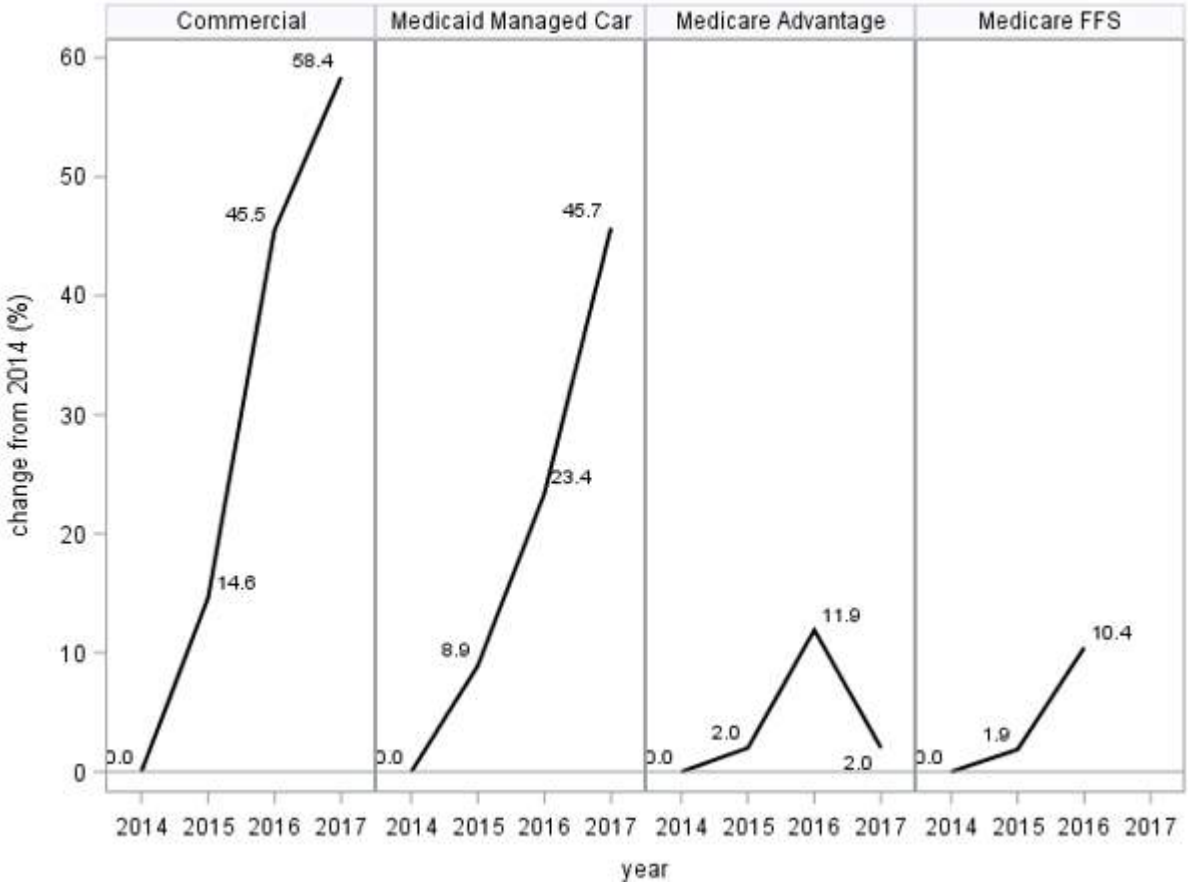
TKR: Volume and Price Trends

- Volume does not appear to be increasing with time.
- This is a vivid demonstration of how prices differ by payer.
- In addition, this demonstrates how prices differ by hospital.
- We tried to understand whether TKR could be traditional TKR and the more modern resurfacing procedures that are advertised in the state. This distinction is probably not possible using CPT codes.
- Note that these data have not been risk-adjusted.

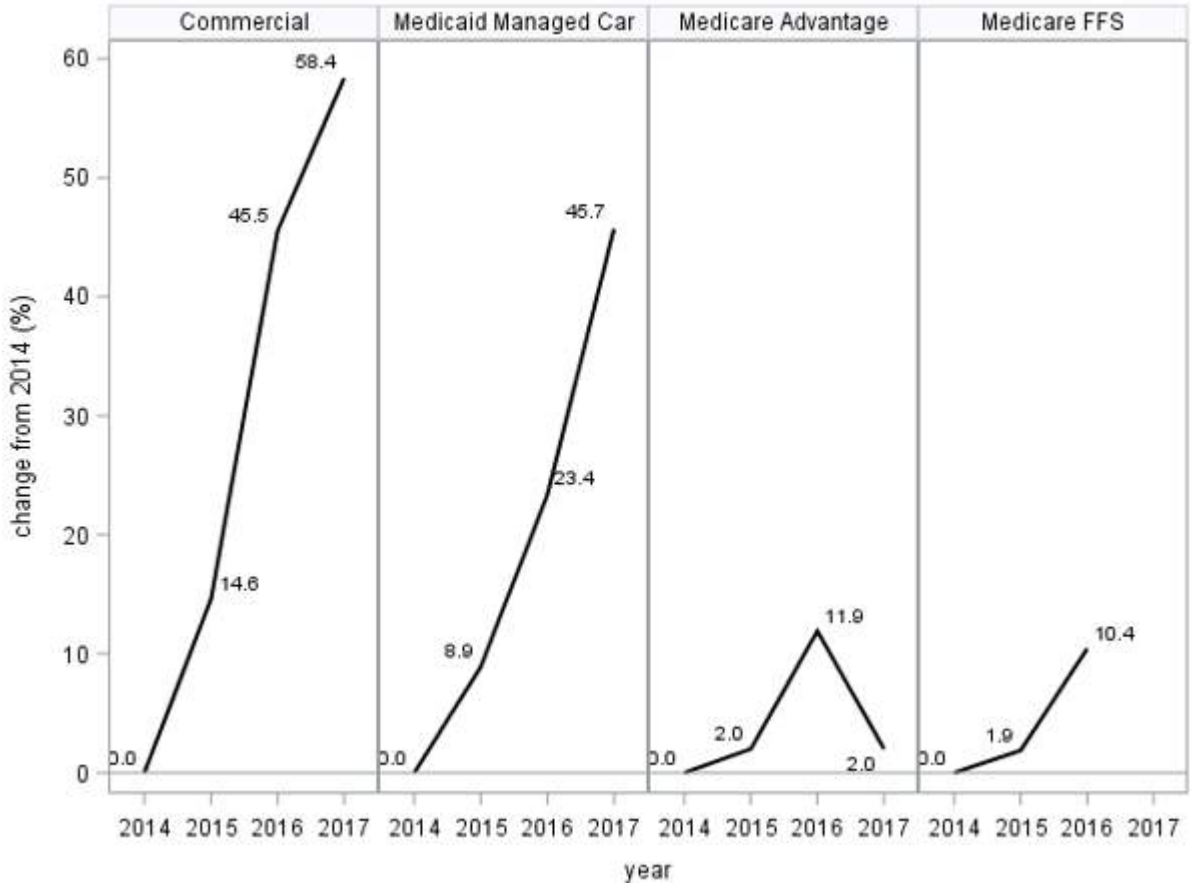
9. Volume vs. Price

DRUG COSTS AS AN EXAMPLE

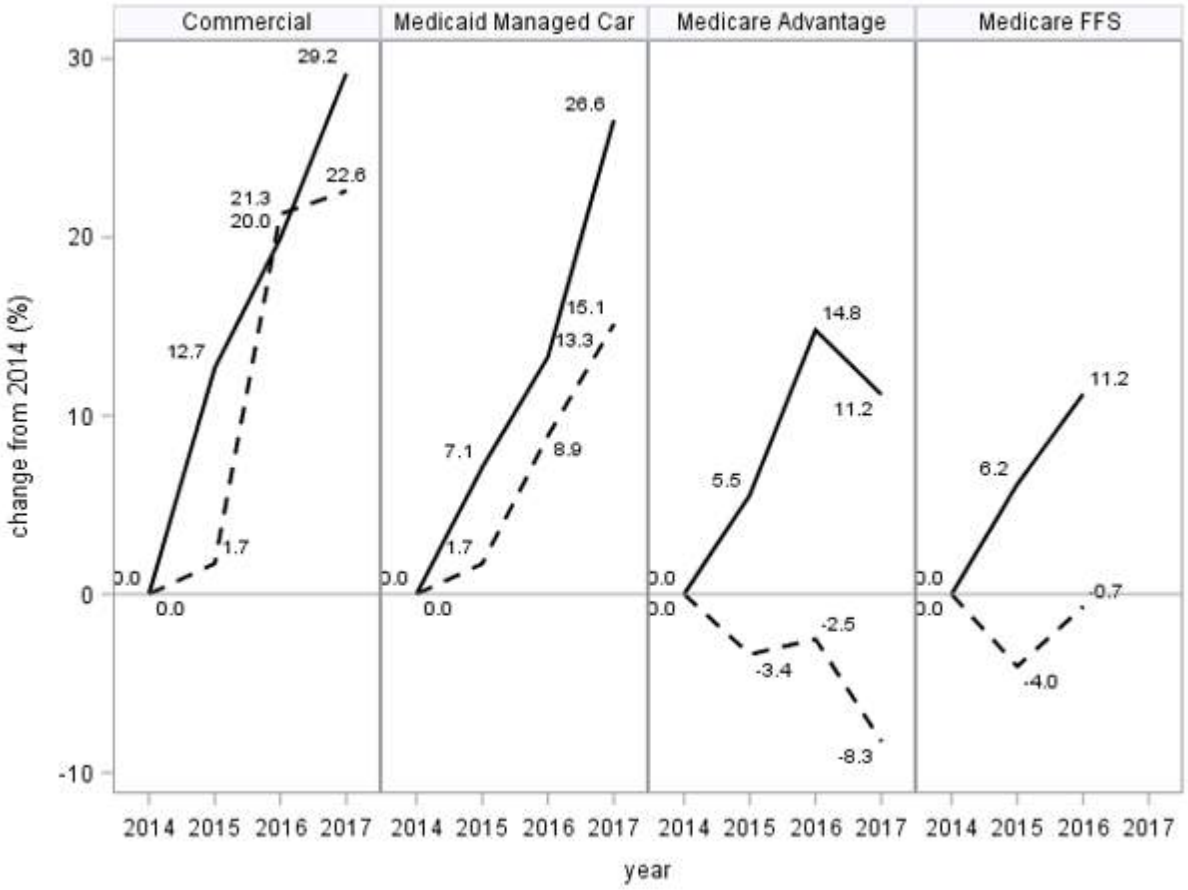
Percent change in total drug costs, by payer, by year, compared to 2014



Percent change in total drug costs, by payer, by year, compared to 2014



Decomposed into utilization (dotted line) and price



Conclusions

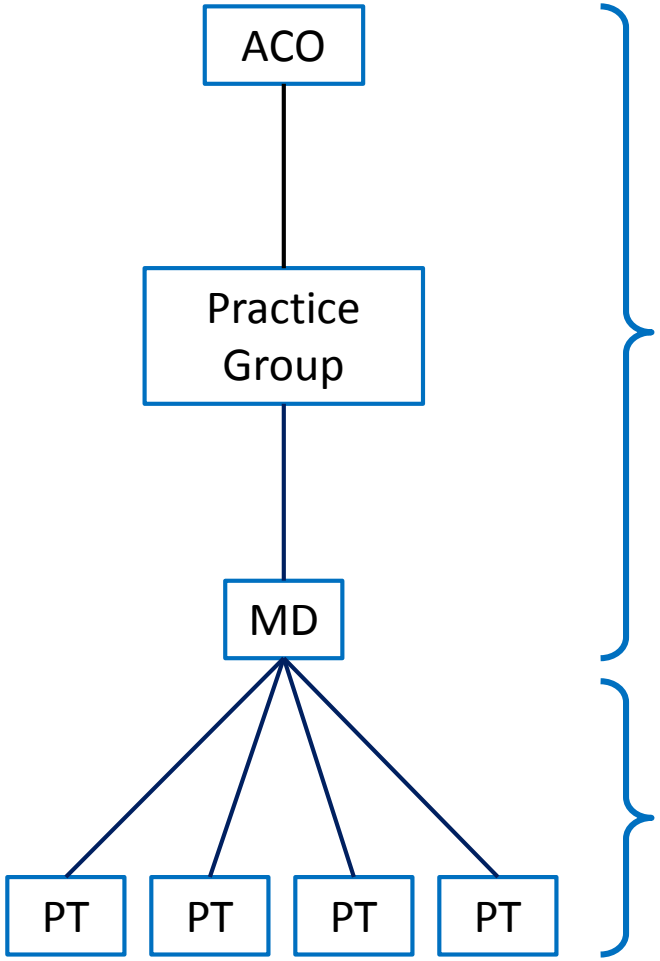
- Decomposing costs into utilization and price per unit is critical.
- Increases in both utilization and price drive commercial drug costs.
- Very different patterns are seen in Medicare Advantage and Medicare FFS as compared with commercial and Medicaid Managed Care.
- Reminder that baseline costs may be higher than optimal.

10. Provider Groups in 2017

Background

- Ability to examine and compare the all-payer performance of provider groups is a critical innovation.
- Because patients in the APCD are de-identified, we have to use patient utilization data to link or attribute patients to providers.
- Providers can then be linked to provider groups and ACOs/AEs.
- Attribution algorithms are complex and computationally intensive.
- Data linking providers to payers, groups, and ACOs/AEs is imperfect.
- All such comparisons require risk adjustment.

Attributing Patients to Providers and Groups



OHIC datasets used to link providers to practice groups and ACOs

Attributing patients to providers

- Look back 27 months
- Identify physicians who provided primary care services
- Attribute the patient to the provider with the plurality of services provided

Initial Attribution Results, 2017

- 1433 unique PCPs in OHIC datasets
- 689,409 unique patients
  - 12.4% (85,527) unattributed
  - 87.6% (603,883) attributed to a PCP
  - 76.3% of all patients (525,909) attributed to a PCP in the OHIC dataset
- Reasons for non-attribution
  - No PCP visits (presumably health people who did not get routine primary care)
  - Attribution to a PCP not in our dataset, perhaps a specialist acting as a PCP

Initial Attribution Results, 2017

- ACOs/AEs in dataset
  - Blackstone Valley Community Health Center (BVCHC)
  - Coastal Medical
  - Integrated Health Partners (IHP)
  - Integra
  - Lifespan
  - Providence Community Health Centers (PCHC)
  - Prospect/Chartercare
- With exception of BVCHC, the number of attributed patients ranges from 25K to 140K – large enough numbers for valid comparisons

Conclusions and Next Steps

- Attribution process performing about as expected.
- Checking and validation of initial attribution results underway.
- Longer-term goal: valid comparisons between ACOs
  - Note that many such comparisons require careful attention to risk adjustment.
  - We are working with “Clinical Risk Groups” or CRGs, a 3M risk-adjustment product that has been used by VT in their APCD work.

11. APCD Data Analysis Conclusions

Conclusions

1. Is Health Facts RI (the APCD) IN ITS CURRENT FORM a viable data source for:

   - Total cost trend analysis? NO
   - Drivers of cost (levels of cost, price and use)? YES
   - Drivers of cost trends? YES
   - Related analyses that could support cost growth reductions and/or quality improvement? YES
   - Comparisons with benchmarks? YES

Conclusions

2. Next Steps

- Attribute patients to PCPs
- Examine trends by provider groups (ACOs)
- Integrate risk adjustment where appropriate
- Examine other examples of “high opportunity” episodes (e.g., maternity care, hip replacement, care of diabetics, etc.)
- Incorporate benchmarks
- Further analyze utilization and price
- Examine of out-of-pocket costs

WA's Experience with Claims Data Analysis and Reporting

THE WASHINGTON HEALTH ALLIANCE STORY

Proposed APCD Data Use Strategy

DRAFT STRATEGY FOR DISCUSSION

Data Use Strategy Introduction

- There were 16 operational state APCDs as of January 2019, with relatively few being effectively leveraged to propel improved health care affordability and quality.

The development of a strategy to make better use of HealthFacts RI, Rhode Island's All-Payer Claims database, lies at the heart of the Cost Trends Project.

November 2018 Conference: *Leveraging Multi-Payer Claims Databases for Value*

Work on the data use strategy began with a 11-14-18 invitational one-day conference. The conference was organized with two objectives:

Objective #1: Learn from individuals from other states whose organizations were currently using multi-payer claims databases

Objective #2: Identify strategies to leverage RI's APCD to enhance the value of health care in Rhode Island

Data Use Categories and Speakers

Data Use Category	State/Organization Invitee
1. Support ongoing **regulatory activity and analysis** of potential policy initiatives	• Tyler Brannen, New Hampshire Insurance Department • Stacey Schubert, Oregon Health Authority
2. Promote **transparency** for consumers and policymakers with **cost and quality reporting and tools**	• Nancy Giunto, Washington Health Alliance • David Auerbach, Massachusetts Health Policy Commission
3. Support specific regional or provider-level **delivery system** activity	• Mary Kate Mohlman, Vermont Blueprint for Health

Takeaways from *Leveraging Multi-Payer Claims Databases for Value*

1. **Actively and continuously engage stakeholders.** Continuous provider and payer engagement are critical to building buy-in and trust, and the State can play the important role of convener. A "co-development" process with providers and payers engaged on the front end allows for collective decision-making about how to best enhance and leverage the APCD.

Takeaways from *Leveraging Multi-Payer Claims Databases for Value*

2. **Responsibly test and then release data.** Data that have been adequately and thoroughly tested, validated, reviewed and analyzed should provide a measure of confidence of readiness for release. Content experts indicated that data integrity does not mean 100% data certainty. National experts and those speaking from experience using multi-payer claims databases suggested a dry run with providers and payers to provide an opportunity to address inconsistencies or errors prior to public release.

Takeaways from *Leveraging Multi-Payer Claims Databases for Value*

3. **Develop a sustainable funding model.** Currently, HealthFacts RI is sustained through Medicaid funding with the state portion of the funding coming from data release fees. Fees are appropriate to assure data requests are valid and from reliable sources, but should not be cost-prohibitive for researchers, as they appear to be. In addition, the State should examine the resources allocated to administering and maintaining the APCD to ensure there are sufficient funds and staff dedicated achieving the goals of the APCD.

Takeaways from *Leveraging Multi-Payer Claims Databases for Value*

4. **Make unwarranted variation transparent.** Exposing variation in utilization, cost, price and quality is an essential use of an APCD dataset. This may be reported at the provider, payer, service and / or geographic levels. Examining variability and benchmarking performance of providers can reveal areas of opportunities for which the State or providers may wish to focus attention and resources.

Takeaways from *Leveraging Multi-Payer Claims Databases for Value*

5. **Identify cost drivers.** Using HealthFacts RI to better understand the primary health care cost drivers in the state is also an essential use of the APCD dataset. The analysis would reveal areas that are contributing in an outsized way to health care spending and focus attention and resources on strategies and interventions to slow the growth. Such analysis would support provider and payer efforts to meet the state's new cost growth target.

Takeaways from *Leveraging Multi-Payer Claims Databases for Value*

6. **Consider the development of a community analytics resource.** There are many providers and payers in Rhode Island that have invested in and developed sophisticated data analytics capabilities to manage health care costs and utilization. It is important to consider how a data use strategy for HealthFacts RI can focus resources to support providers with less advanced data capabilities and not duplicate efforts.

Post-Conference Activity

- Follow-up conversations with the November conference presenters to further explore their activities and learnings
- Focus groups with physicians, non-physician clinicians and other provider representatives
- Multiple Steering Committee discussions of priorities for use of the APCD
- Dissemination of draft strategy document for Steering Committee comment (twice) and for public comment, and then revisions.

APCD Data Use Strategy Proposal

The Steering Committee considered two types of analyses that can be performed with HealthFacts RI data:

1. routinely produced, commonly structured analyses to be published on a regular schedule, and
2. ad hoc analyses focusing on discrete topics of interest to the State and to Rhode Island stakeholders.

This recommended APCD data use strategy focuses upon the former - routinely produced, commonly structured analyses to be published on a regular schedule.

APCD Data Use Strategy Proposal

The Steering Committee agreed upon the following when shaping its recommendations:

1. Prioritize reports first for provider use, and second for the general public.
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.
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.

APCD Data Use Strategy Proposal

The Steering Committee recommends that a data use strategy for HealthFacts RI focus upon five types of analyses.

Each of type of analysis should produce a report that:

- is produced with stratification by insurance coverage (e.g., commercial, Medicaid, Medicare);
- is produced by provider and, when appropriate, by geography;
- when possible, incorporates stratification of children and adults, and
- displays performance change over time.

The State should ensure that only statistically valid performance data are published.

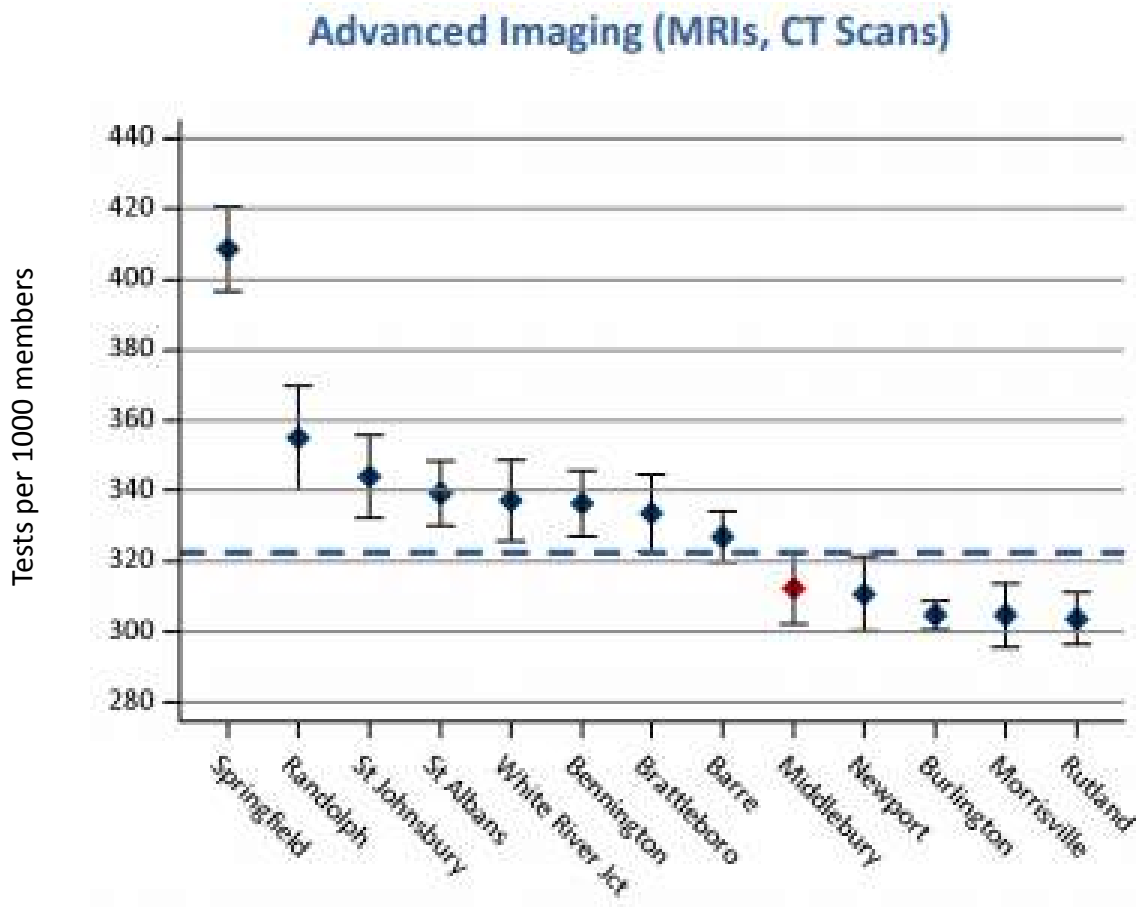
Five Recommended Analyses for Public Reporting - in Priority Order

1. cost drivers
   - utilization variation: frequency, intensity and site of care
   - price and cost variation: by service (price) and by episode of care (cost)
2. cost growth drivers
3. cost drivers (cont'd)
   - low-value services
   - potentially preventable services
4. population demographics, including social determinants of health
5. quality of care

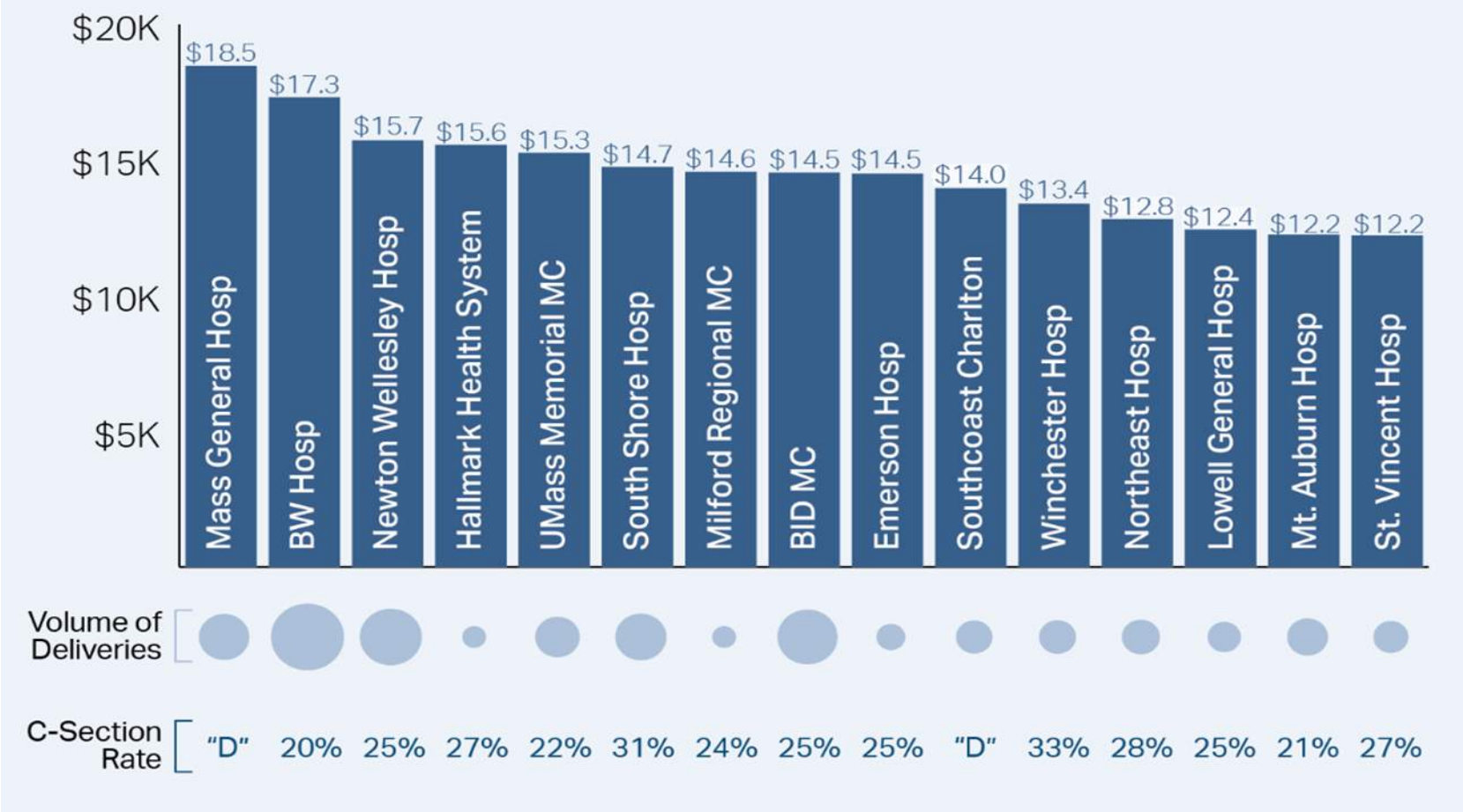
Report Type #1: Cost Drivers

- Isolates the impact of service utilization and unit price/cost.
- Looks at how cost drivers vary within RI (by geography, payer, population, insurer, large provider)
- Looks at how performance compares to benchmarks external to RI (to the extent available)

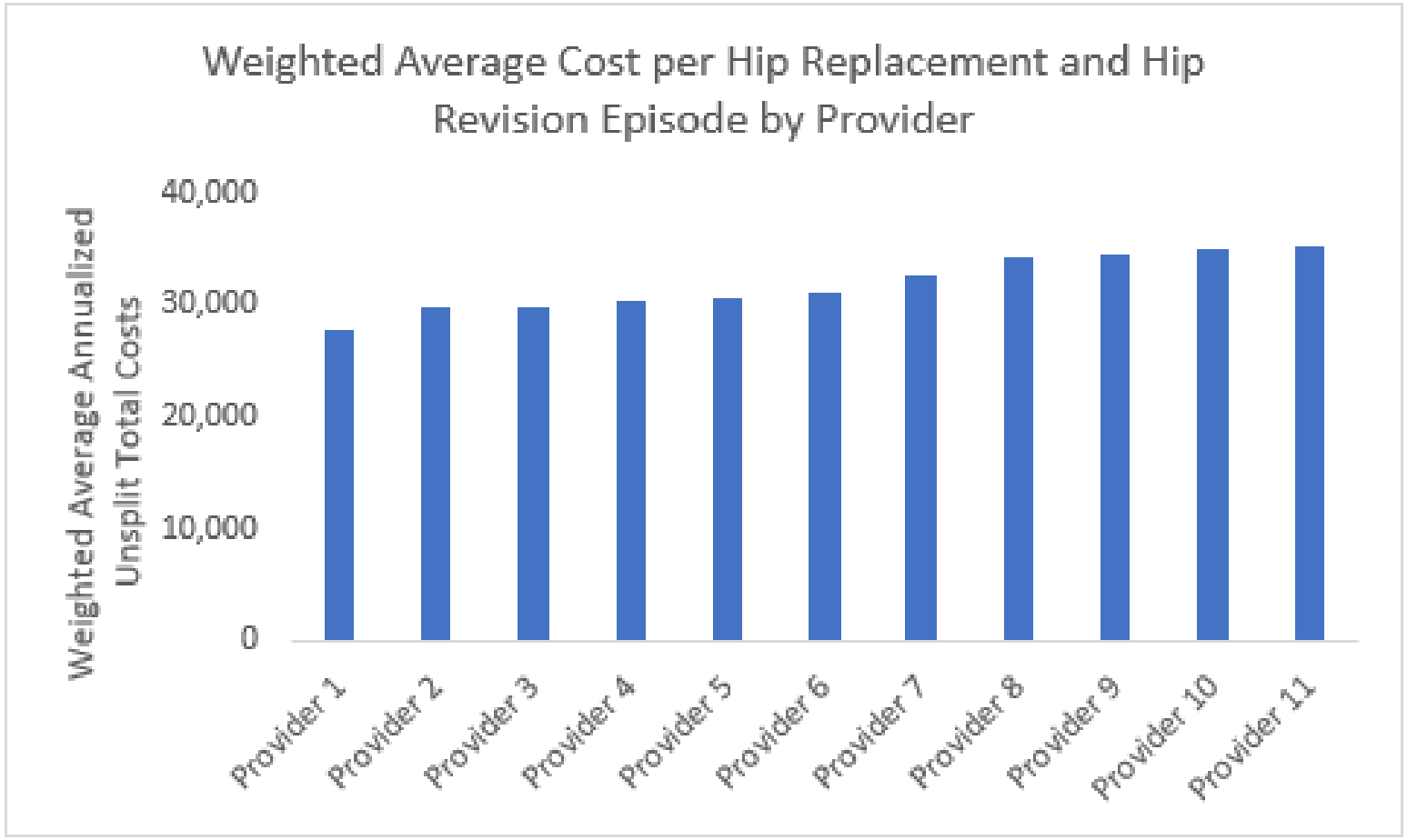
Report Type #1: Cost Drivers Vermont Utilization Example



Report Type #1: Cost Drivers Massachusetts Cost Example



Report Type #1: Cost Drivers
Rhode Island Cost Example



Report Type #2: Cost Growth Drivers

- Identifies the factors that most contributed to cost growth over time (one year or more)
- Can provide insight into the causes underlying performance relative to the annual Cost Growth Target of 3.2%

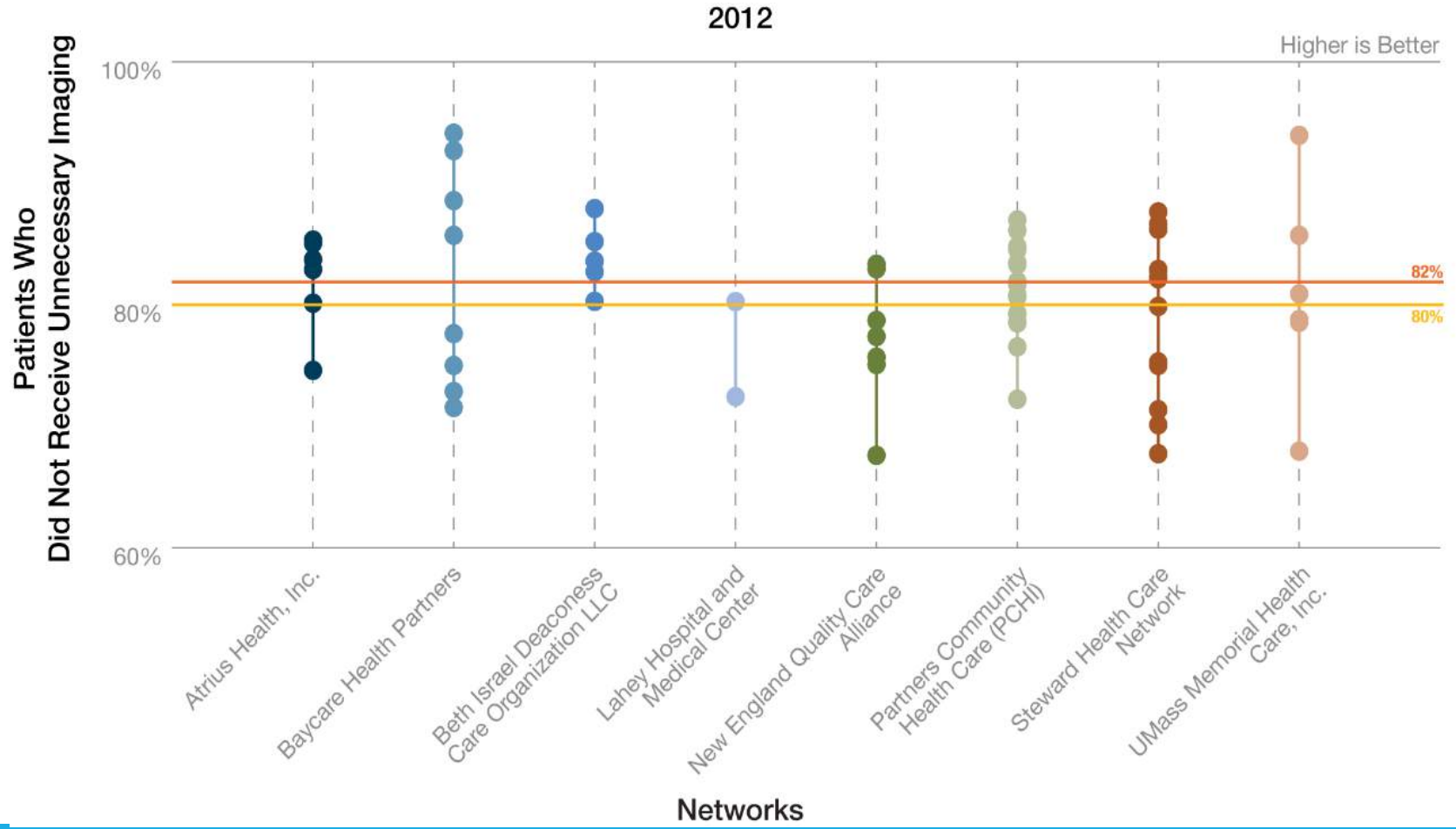
Report Type #2: Cost Growth Drivers Washington Health Alliance Example

Service	THIS YEAR's Spending (PMPM)	LAST YEAR's Spending (PMPM)	Change (%)	Change (PMPM)	What is contributing to the change in spending? (PMPM) changes in Age/Gender Mix account for:	changes in Service Frequency account for:	changes in Treatment Intensity account for:	changes in Price Level account for:	Total Change in Spending
Pulmonary Edema	$22.90	$21.99	4.2%	$0.92	$0.08	($0.05)	($0.01)	$0.89	$20,612
COPD	$18.99	$17.66	7.5%	$1.33	$0.11	$0.25	$0.44	$0.53	$29,908
Pneumonia	$27.32	$25.40	7.5%	$1.91	$0.17	$0.14	$0.16	$1.43	$43,023
Perc CV Procedures	$26.45	$25.13	5.3%	$1.32	$0.15	$0.03	$0.03	$1.12	$29,756
Circulatory Disorders	$18.88	$18.12	4.2%	$0.76	$0.09	$0.00	$0.01	$0.65	$16,988
Heart Failure	$22.77	$22.31	2.0%	$0.46	$0.06	($0.00)	($0.00)	$0.40	$10,246
Cardiac Arrhythmia	$27.33	$26.51	3.1%	$0.82	$0.09	$0.01	$0.05	$0.66	$18,445
Spinal Fusion	$13.70	$12.88	6.4%	$0.82	$0.06	$0.33	$0.08	$0.35	$18,492
Major Joint Replacement	$16.08	$15.11	6.4%	$0.96	$0.08	$0.14	$0.20	$0.55	$21,706
Cellulitis	$28.26	$25.72	9.9%	$2.54	$0.13	$1.53	$0.01	$0.89	$57,227
Metabolic disorders	$19.26	$17.53	9.9%	$1.73	$0.07	($0.06)	($0.01)	$1.73	$39,006
Urinary Tract Infections	$23.01	$22.55	2.0%	$0.46	$0.03	$0.18	$0.27	($0.01)	$10,355
Septicemia	$10.93	$10.60	3.1%	$0.33	$0.01	$0.12	$0.13	$0.07	$7,377
	$275.87	**$261.51**	**5.5%**	**$14.36**	**$1.13**	**$2.62**	**$1.35**	**$9.27**	**$323,141**
					8%	**18%**	**9%**	**65%**	

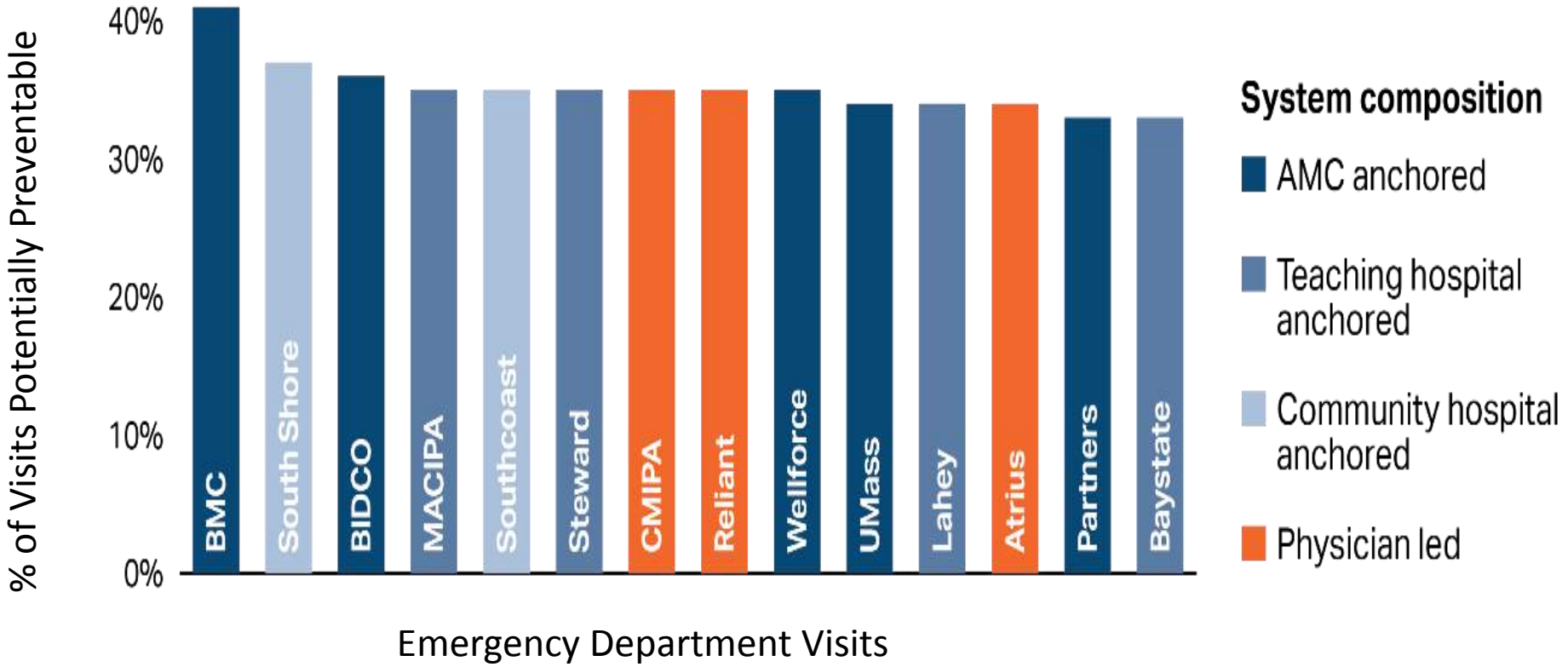
Report Type #3: Cost Drivers (Cont'd)

- Focuses on utilization and spending associated with poor quality care due to overuse and underuse
  - low-value services: services that produce little to no benefit to the patient
  - potentially preventable services: spending on acute services that could have been avoided if preceded by high quality ambulatory care

Report Type #3:
Mass. Low-Value Care Example



Report Type #3:
Mass. Potentially Preventable Example



Report Type #4: Population Demographics

- Involves supplementing the APCD with data from other sources (e.g., race, language, ethnicity, housing status, income, etc.) to facilitate identification of high-risk communities, and more generally enhance an understanding of served communities.
- "Hot spotting" analysis could help providers target particular high-risk communities, and even neighborhoods, within their service area.

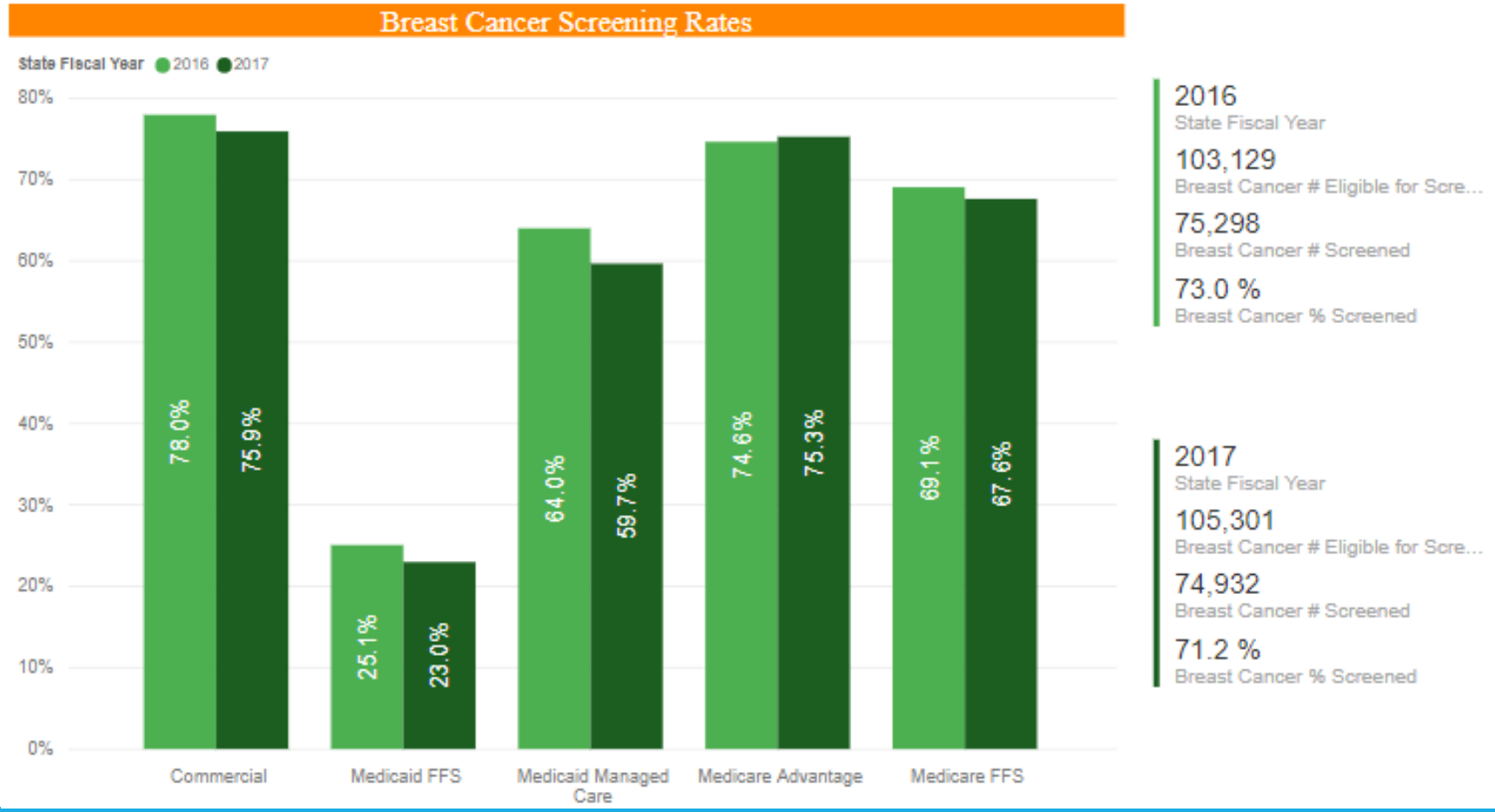
Report Type #4:
Mass. Pop. Demographics Example

	Risk score	Zip-code income	Area deprivation index	% over 55	% Self-insured	% Female
Atrius	.96	$83,284	76.7	26%	52%	56.4%
BMC	.89	$63,319	88.5	20%	52%	54.2%
Lahey	1.05	$85,677	77.8	31%	43%	51.7%
MACIPA	.94	$85,615	70.1	28%	47%	53.5%
Partners	1.03	$86,017	76.6	29%	44%	55.5%
Southcoast	1.09	$59,721	97.6	30%	50%	51.4%
Steward	1.05	$70,131	90.1	30%	48%	52.4%
All physician-led	.96	$81,723	80.2	25.8%	47.8%	55.3%
All other hospital-anchored	1.02	$74,485	86.6	29.8%	45.7%	52.6%
All AMC-anchored	1.02	$81,646	80.7	28.3%	44.5%	53.7%

Report Type #5: Quality

- While there are limitations to how quality can be measured using claim data alone, there are valid and valuable measures for which claim data can be useful (e.g., readmission rates).
- Quality reports would focus on aspects of performance for which comparative analyses are not currently available.

Report Type #5:
Rhode Island Quality Example



Report Type #5:
Washington Health Alliance Quality Example

Healthier WASHINGTON

Powered by: COMMUNITY CHECKUP

Figure 18: Ranking Medical Group Performance for **Commercially Insured**: Medical Groups That Have Results for **15 or More** Measures

Discussion

SHOULD THE PROPOSED APCD DATA USE STRATEGY BE MODIFIED, AND IF SO, HOW?

Next Steps and Wrap-up

Next Steps

- Thank you for participating in the meeting today!
- The project team will consider your feedback as it continues to refine its APCD analyses.
- The project team will also incorporate your feedback on the data use strategy into the final RI Cost Trends Project Data Use Strategy, which will be posted on the OHIC website by the end of June: http://www.ohic.ri.gov/ohic-reformandpolicy-costtrends.php.

Thank you!