

Rhode Island Health Care Cost Trends Steering Committee

FIFTH MEETING, NOVEMBER 5, 2018



Agenda

1. Welcome 9:00 am – 9:05 am
2. Data Use Strategy: November 14th Conference 9:05 am – 9:20 am
3. Analysis of APCD: Update 9:20 am – 9:30 am
4. Cost Growth Target: Data Source Revisited 9:30 am – 9:40 am
5. Cost Growth Target: Provider Attribution and Risk Adjustment 9:40 am – 10:20 am
6. Break 10:20 am – 10:30 am
7. Cost Growth Target: Setting the Target and Timeline 10:30 am – 11:15 am
8. Cost Growth Target: Reporting Performance 11:15 am – 11:45 am
9. Public Comment 11:45 am – 11:55 am
10. Next Steps and Wrap-Up 11:55 am - Noon

Data Use Strategy

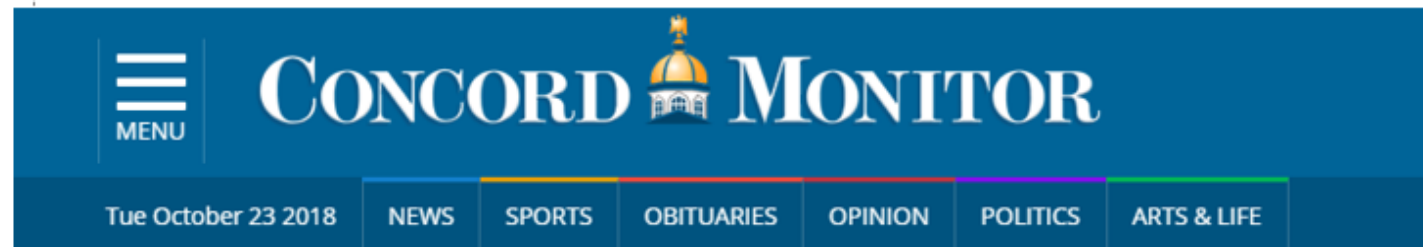
LEVERAGING MULTI-PAYER CLAIMS DATABASES FOR VALUE CONFERENCE

Data Use Categories and Speakers

Data Use Category	State/Organization Invitee
1. Support ongoing regulatory activity and analysis of potential policy initiatives	<ul style="list-style-type: none">• Tyler Brannen, New Hampshire Insurance Department• Stacey Shubert, Oregon Health Authority
2. Promote transparency for consumers and policymakers with cost and quality reporting and tools	<ul style="list-style-type: none">• Nancy Giunto, Washington Health Alliance• David Auerbach, Massachusetts Health Policy Commission
3. Support specific regional or provider-level delivery system activity	<ul style="list-style-type: none">• Mary Kate Mohlman, Vermont Blueprint for Health

Data Use Case 1a: Support ongoing regulatory activity and analysis of potential policy initiatives

The **New Hampshire Insurance Department** has used its APCD to evaluate/inform policy decisions on many issues, including reimbursement rates for mental health services, cost drivers and balance billing. Most recently, the Department began using the APCD to monitor the impact of the state's new network adequacy regulation (IR 2701), which measures adequacy by service category rather than provider type.



[News](#) > [State](#)

N.H. to become first state to use health insurance claims to rate networks

Data Use Case 1b: Support ongoing regulatory activity and analysis of potential policy initiatives

Oregon Health Authority has produced a [use case document](#), listing the ways in which All-Payer All Claims (APAC) data had been used and by the different internal and external parties. It has recently been using its APAC data to inform discussions of payment rates for out-of-network balance billing.

As defined in Oregon's statutes, the purpose of APAC is to:

- Help determine health care resource allocation
- Identify the demands for health care
- Help health care policymakers make informed choices
- Evaluate the effectiveness of intervention programs in improving health outcomes
- Compare the costs and effectiveness of various treatment settings and approaches
- Provide information to consumers and purchasers of health care
- Improve the quality and affordability of health care and health care coverage
- Assist in furthering state health policies
- Evaluate health disparities

APAC Overview: www.oregon.gov/oha/HPA/ANALYTICS/APAC%20Page%20Docs/APAC-Overview.pdf

Data Use Case 2a: Promote transparency for consumers and policymakers with cost and quality reporting and tools

The **Washington Health Alliance**, a regional health improvement collaborative, reports on health care quality, regional variation in utilization of specific services and wasteful spending.

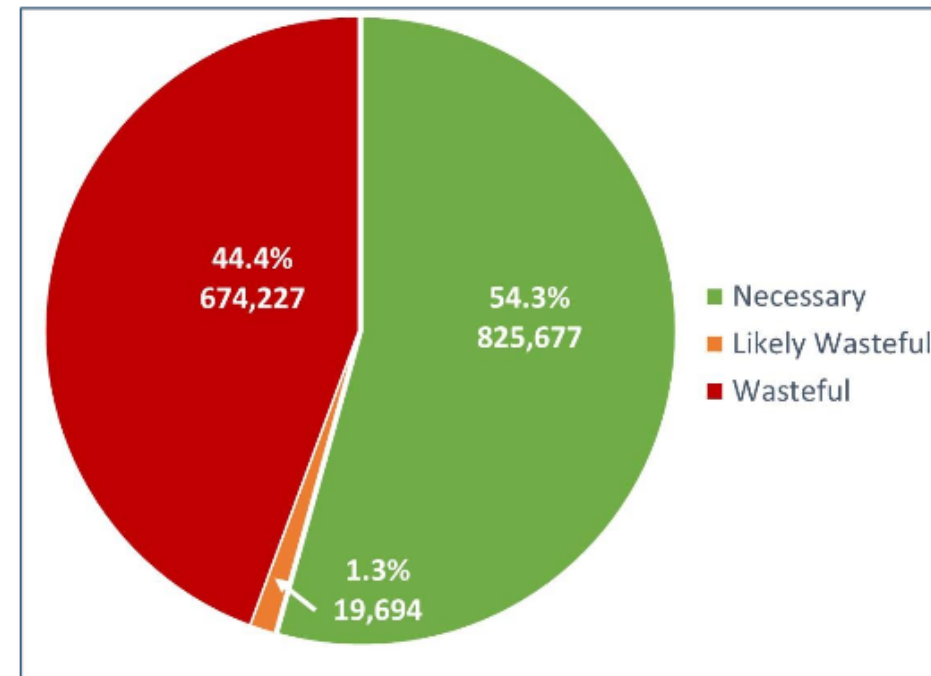
In Feb. 2018, WHA reported on low-value health care services, measuring 47 common tests, procedures and treatments that Choosing Wisely and the U.S. Preventive Services Task Force have determined are overused

Source: *First, Do No Harm: Calculating Health Care Waste in Washington State*, Feb 2018

<https://wahealthalliance.org/alliance-reports-websites/alliance-reports/first-do-no-harm/>

Results from the Health Waste Calculator

The following is a high-level summary of the results based on the 47 Health Waste Calculator measures included in this analysis.



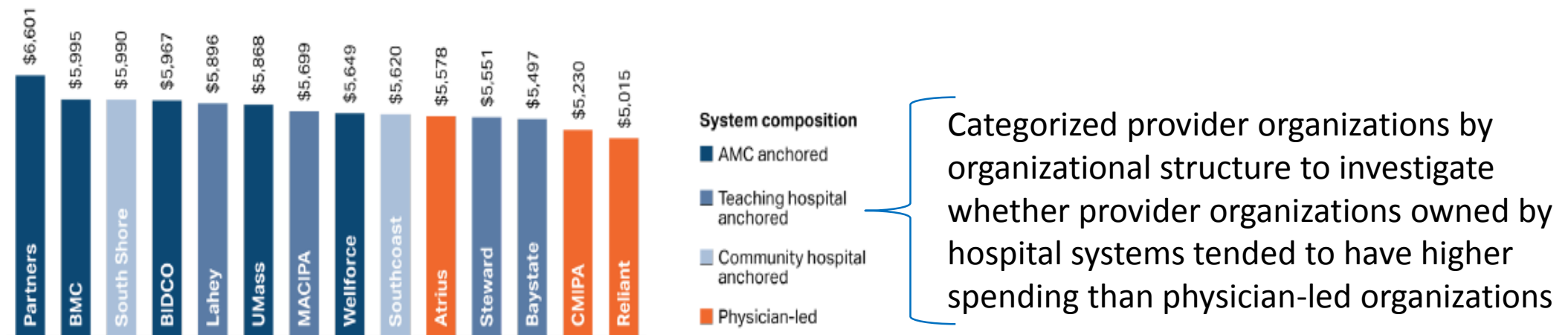
1.52 million **SERVICES** were examined

45.7% of services were determined to be low-value

Data Use Case 2b: Promote transparency for consumers and policymakers with cost and quality reporting and tools

The **Massachusetts Health Policy Commission** uses data from the state's APCD (and other sources) to produce an annual "Cost Trends Report", analyzing trends in health care spending and delivery; evaluating progress in key areas; and developing policy recommendations for strategies to increase quality and efficiency. Past reports have looked at variation in total spending, cost variation by provider, and rates of the provision of low-value services across provider organizations.

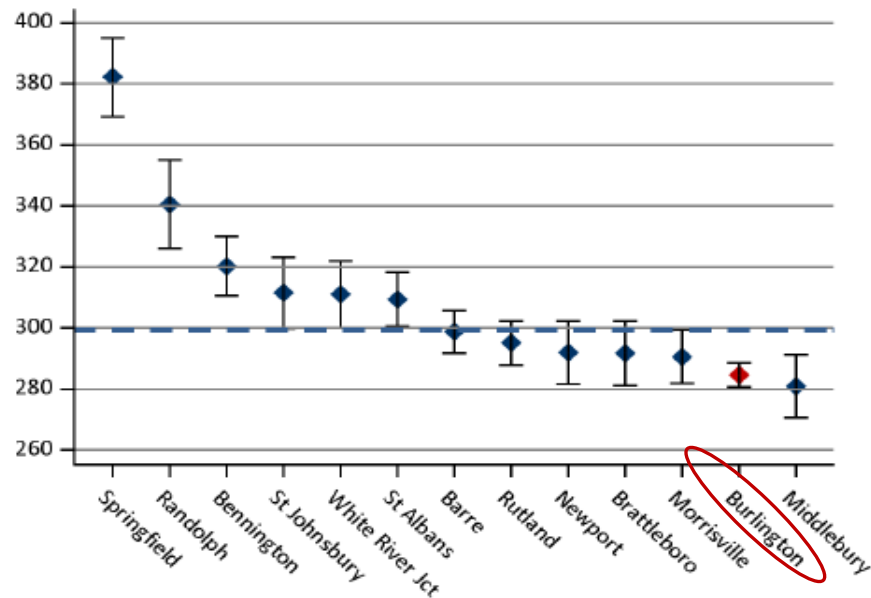
EXHIBIT 4.3 Average risk-adjusted commercial spending per member per year, by provider organization, 2015



Data Use Case 3: Support specific regional or provider-level delivery system activity

The **Vermont Blueprint for Health** produces bi-annual regional service area profiles of health status, utilization and quality measures. Regional collaboratives use community health profile data to identify and address performance improvement opportunities, and practices use practice profiles to identify and address opportunities for improvement.

Advanced Imaging (MRIs, CT Scans)



- Annual risk-adjusted rates, including 95% confidence intervals, of advanced imaging diagnostic tests (i.e., MRIs and computed tomography (CT) scans) per 1,000 members.
- Blue dashed line represents the statewide average
- All community profiles are publicly available at: <http://blueprintforhealth.vermont.gov/community-health-profiles>

Morning Speaker Presentations: Questions They Will Address

1. Please *briefly* provide some context about your multi-payer claims database.
 - a. How many and which payers are submitting data to your database (e.g., commercial, Medicaid, Medicare)?
 - b. What resources are dedicated to analyzing the data collected and converting it into meaningful, actionable reports/uses? (This is distinct from the resources needed to maintain the database, including validating data, etc.)
 - c. Are you supplementing claims data from the database with other data sources? If so, how?
 - d. How have you addressed gaps in data to achieve your goals?
 - e. When did your database become fully operational and when did you begin implementing your data use strategies?
 - f. Are there any limitations on the use of the data (e.g., statutory limits)?
2. Data Use Cases (majority of presentation): How are you leveraging your multi-payer claims database resource to advance health care system improvement?

Examples of Moderated Questions

1. Do you have evidence of the impact your data applications have had on health system performance or payer/provider/consumer behavior changes?
2. What have you learned and what you recommend to Rhode Island? (Please consider what's worked and what hasn't worked.)

Are there other questions you have that we should queue up for the speakers?

Afternoon Panelist Roundtable

- Moderated panel discussion about how providers, payers and / or the State leverage RI's APCD to enhance the value of health care.
- Panelists: two subject matter experts, two state officials and two provider members of the Steering Committee (Al and Jim)
- *Sample question*:
 - Which of the practices described this morning has strong potential to generate high value for Rhode Island?

Are there other questions you have that we should queue up for the panelists?

Analysis of Health Facts

Brown Status Update

Follow-up on Topics from Prior Meetings

- Data Source
- Attribution
- Risk Adjustment

Data Source Revisited

Data Source for Calculating Performance Relative to the Target

During our last meeting on 10/15 the Steering Committee supported the option of utilizing payer-reported spending calculations for the purpose of 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 ACPD is not utilized.

For this reason, they propose that the Steering Committee a) defer finalizing a recommendation on data source for assessing performance until this research can be completed and b) proceed with finalizing all other elements of the methodology recommendation in November.

As a reminder, calculations won't occur until mid-2020, so we have time to resolve this question.

Data Source for Calculating Performance Relative to the Target (Cont'd)

Questions to be considered by Brown:

- What impact will the missing 53% of self-insured commercial spending have on trend calculations?
- What impact will missing non-claims-based payments have on trend calculations?
- Is it possible for payers to provide non-claims-based payments at the line-of-business and high-volume provider levels to supplement APCD data?

Questions to be considered by Brown and Bailit Health:

- What would be the effort for the State or its agent to annually analyze payer-reported data to calculate performance against the target at all levels?
- What would be the effort for the State or its agent to annually analyze APCD data to calculate performance against the target at all levels?

Cost Growth Target: Patient Attribution and Risk Adjustment

Patient Attribution: The “How”

During the 10/15 meeting we discussed patient attribution.

Reminder: Performance against the target needs to be reported on a *per capita* basis because doing so takes into account the three driving factors of health care spending growth: price, volume and service mix.

To report on a per capita basis, the spending of patients/members needs to be attributed to one provider.

Decision: The group weighed different attribution approaches and agreed that the methodology of assessing performance against the cost growth target will use existing payer attribution methodologies and not a common methodology.



Patient Attribution: The “Who”

During the 10/15 meeting we discussed which provider entities would members be attributed to for the purposes of calculating per-capita spending and assessing cost growth target performance.

The Steering Committee debated whether to use the **ACO contracting unit** or the **provider-corporate entity** as the primary unit of analysis.

Payer representatives of the Steering Committee were tasked with considering the operational implications of reporting patient attribution by ACO and to come prepared to discuss their findings.

Following the 10/15 meeting, payers shared that they are able, and preferred, to report patient attribution by ACO, but noted that not all ACOs are contracted for all lines of business.

Patient Attribution: The “How Many”

During the 10/15 meeting we began discussions on the minimum number of attributed members a provider would need for its performance to be assessed.

Bailit Health used statistical analyses performed with claim data for a very large adult Medicaid population in a non-New England state to assess the impact of population size and variation on performance from a cost target on statistical confidence.

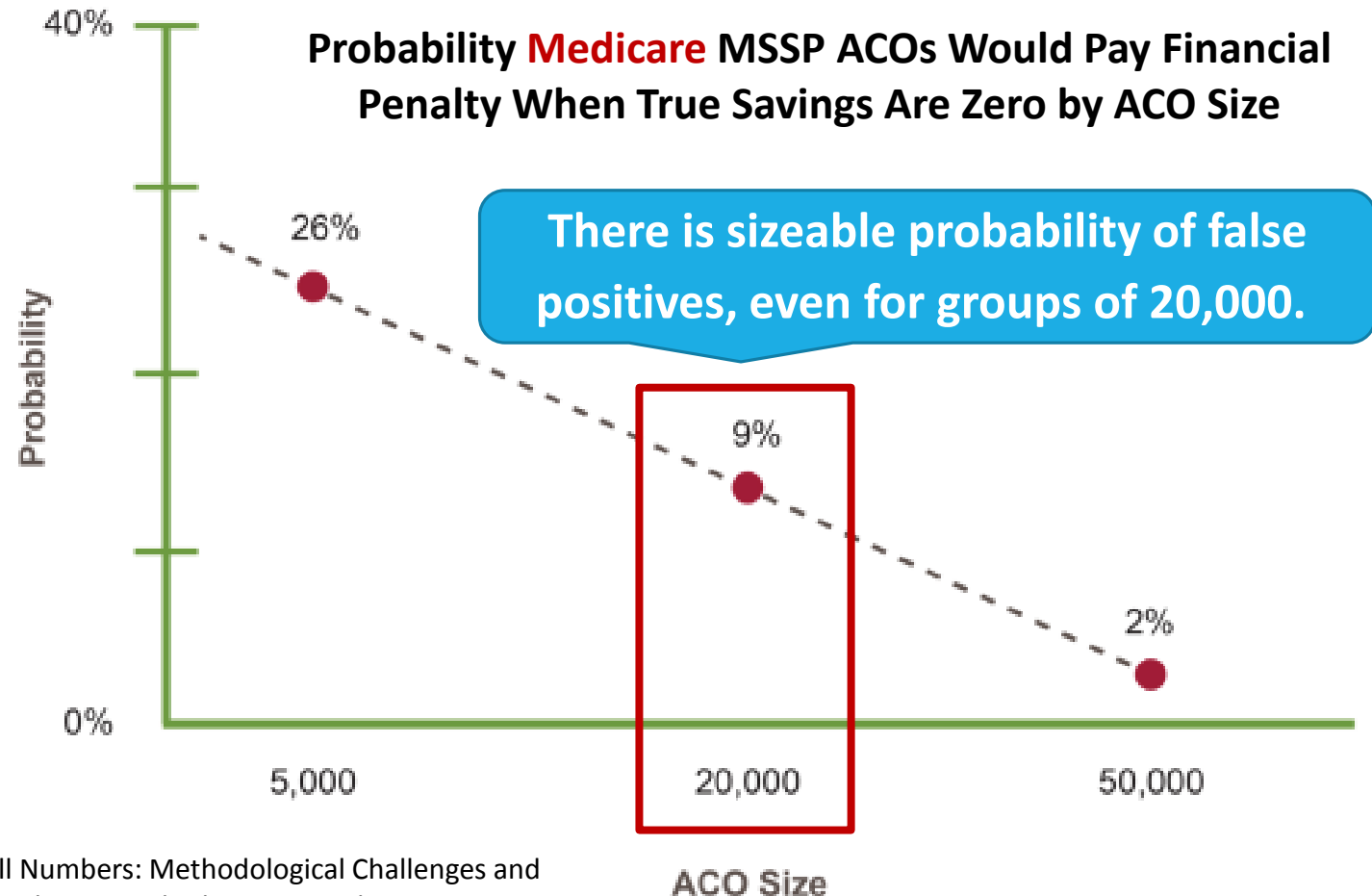
Key considerations when interpreting the modeling:

- Includes Medicaid managed care data
- Excludes children
- Truncates high-cost outliers
- Extrapolates findings to providers of sizes not modeled in the initial analysis

Patient Attribution: The “How Many”

Context: 2016 RWJF Brief on False Positives

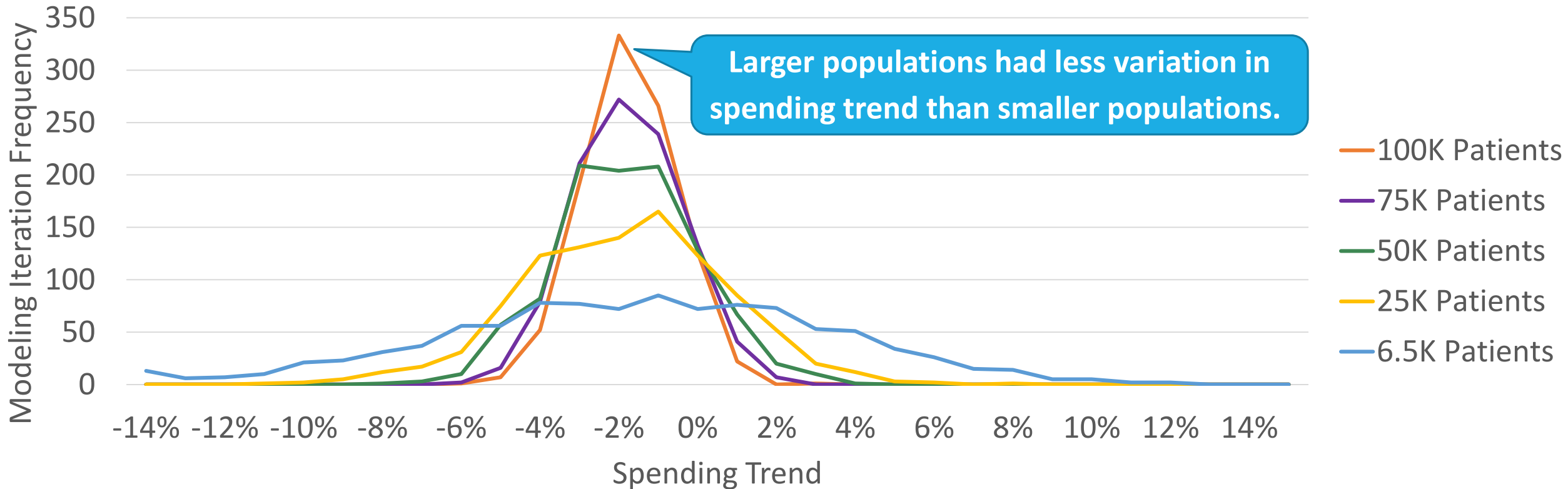
For our purposes, a “false positive” is when spending observed above the target is due to random variation, while “actual” spending trend is below the target.



McCall, N., & Peikes, D. (2016, April). Tricky Problems with Small Numbers: Methodological Challenges and Possible Solutions for Measuring PCMH and ACO Performance. Robert Wood Johnson Foundation.

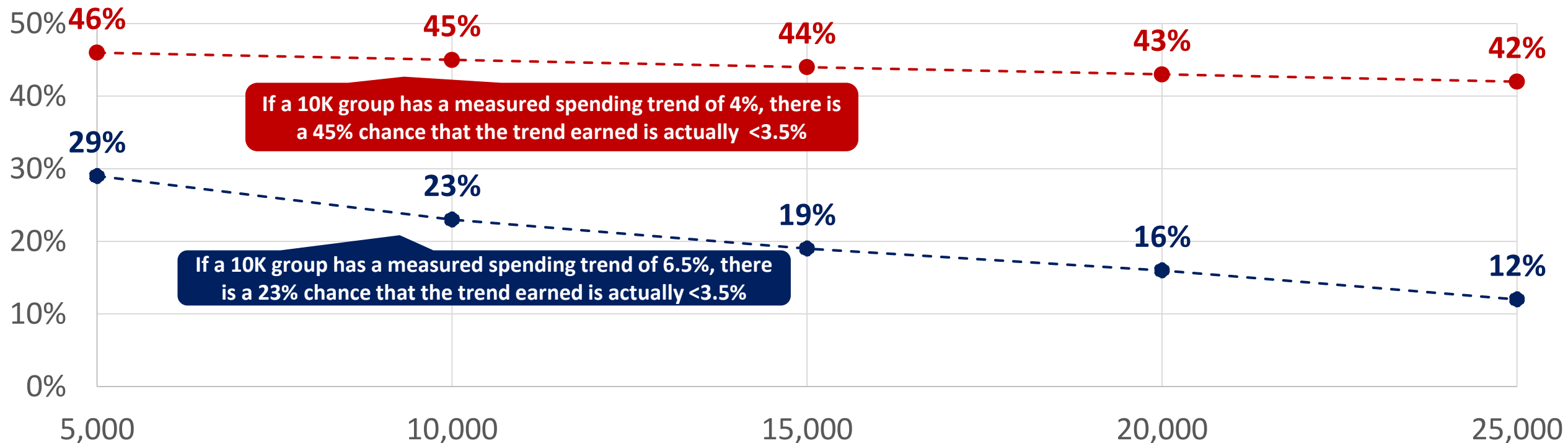
Patient Attribution: The “How Many” *Analysis: Random Variation in Savings*

Frequency of Spending Trend by Population Size



Patient Attribution: The “How Many” *Analysis: Random Variation vs. True Trend*

Probability of a measured **4%** or **6.5%** spending trend reflecting a 'true' trend of **<3.5%**



Patient Attribution: The “How Many”

During the 10/15 meeting, Steering Committee staff recommended **10,000** because of concerns about statistical robustness and random variation. (Massachusetts’ minimum is 3,600.)

Concerns were raised by Steering Committee members that too many provider groups / ACOs would fall below a minimum set at 10,000 because of the size of the state and its providers.

Steering Committee staff therefore undertook research and learned the following from insurers:

- Inclusion of provider contracts with 10,000+ attributed lives by line of business would produce **15 reports of provider-specific performance** across payers.
- Inclusion of provider contracts with 5,000 to 9,999 attributed lives would produce **25 reports of provider-specific performance** across payers.

Patient Attribution: The “How Many”

What else does this research tell us?

Each report of provider-specific performance represents one line of business for one payer. Given the number of ACOs and AEs in the state it tells us that if payers were to generate provider-level analyses:

- there will be fewer than 10 ACOs/AEs reported in the state;
- if payers are reporting performance, some of the largest ACOs and AEs would not have all payers or all lines of business reported, and
- if the APCD is used, populations across payers could be combined resulting in more reporting of performance.

Example of Provider Performance Reporting from Massachusetts

Managing Physician Group	Insurance Category	Payer	2013-2014 H.S.A TME Growth Rate	2014-2015 H.S.A TME Growth Rate
Atrius Health	Comm. Full-Claim	Blue Cross Blue Shield of Massachusetts	-3.8%	3.1%
Atrius Health	Comm. Full-Claim	Fallon Health	N/A	N/A
Atrius Health	Comm. Full-Claim	Harvard Pilgrim Health Care	1.2%	-2.9%
Atrius Health	Comm. Full-Claim	Neighborhood Health Plan	294.6%	-11.6%
Atrius Health	Comm. Full-Claim	Tufts Health Plan	7.8%	-0.3%
Atrius Health	Medicaid	Fallon Health	N/A	N/A
Atrius Health	Medicaid	Neighborhood Health Plan	394.7%	-6.3%
Atrius Health	Medicare	Tufts Health Plan	3.5%	-5.0%
Baycare Health Partners, Inc.	Comm. Full-Claim	Blue Cross Blue Shield of Massachusetts	6.5%	-1.8%
Baycare Health Partners, Inc.	Comm. Full-Claim	Fallon Health	N/A	5.8%
Baycare Health Partners, Inc.	Comm. Full-Claim	Harvard Pilgrim Health Care	0.6%	-2.7%

Source: Center for Health Information and Analysis

Risk Adjustment

The composition of a payer's or provider's population – including its clinical risk profile - may change over the course of the year.

Such changes will have an impact on spending growth, e.g., a population that is sicker than a year prior should be expected to have higher health care spending.

For this reason, assessment of payer and provider performance relative to the target should be adjusted for population clinical risk.

Such an adjustment is not required at the state level since the state population is expected to be fairly stable over the course of one year.

Risk Adjustment Approach

Given that further consideration will be given to data sources, Steering Committee staff recommend the following approach, contingent on the future data source decision:

Data Source	Method	Rationale
1. Payer-Reported Data	Each insurer uses its own risk adjuster	Very burdensome for insurers to all use the same software.
2. APCD	A common risk adjuster(s) is used on all claims data within the APCD. Could vary of market (e.g., commercial, M'care, M'caid).	Achieves a high level of uniformity; little logic supporting use of payer-specific methods with markets.

Cost Growth Target

- Setting the Target
- Timeline

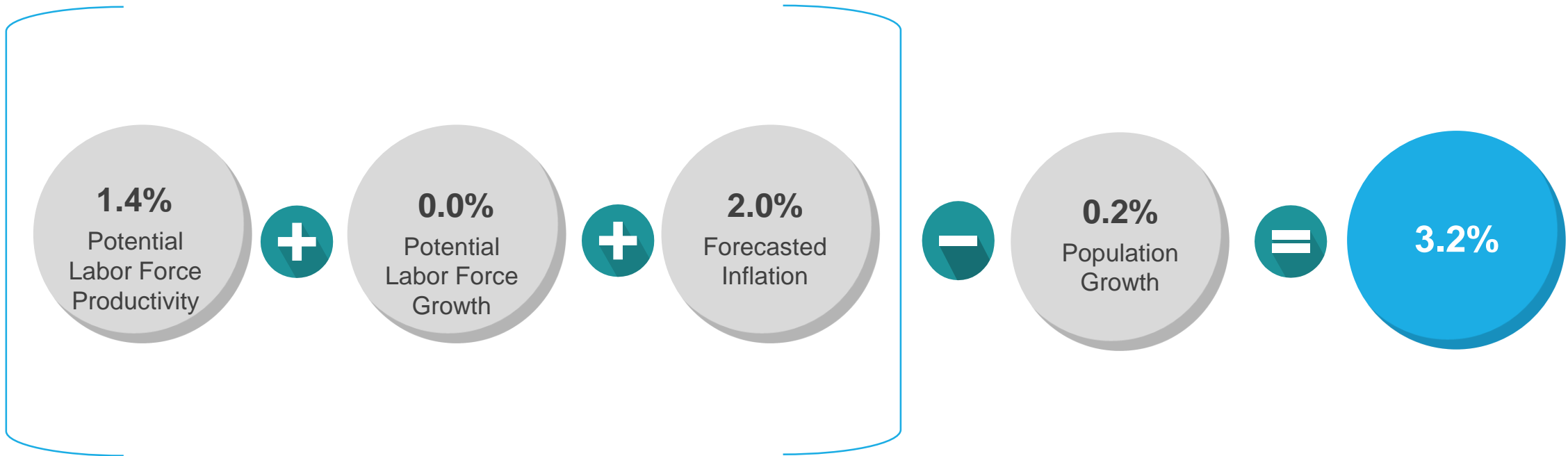
Cost Growth Target for 2019

During our last meeting, the Steering Committee supported the Co-Chairs' recommendation of setting a cost growth target at the forecasted Rhode Island Potential Gross State Product (PGSP).

PGSP is the total value of the goods produced and services provided in a state at a constant inflation rate. PGSP is also used in Massachusetts and will be used in Delaware.

We will share the value of PGSP, put it into context, then ask whether there should be an adjustment and if so, how much and whether the adjustment should change over time.

Rhode Island's Forecasted Growth in PGSP



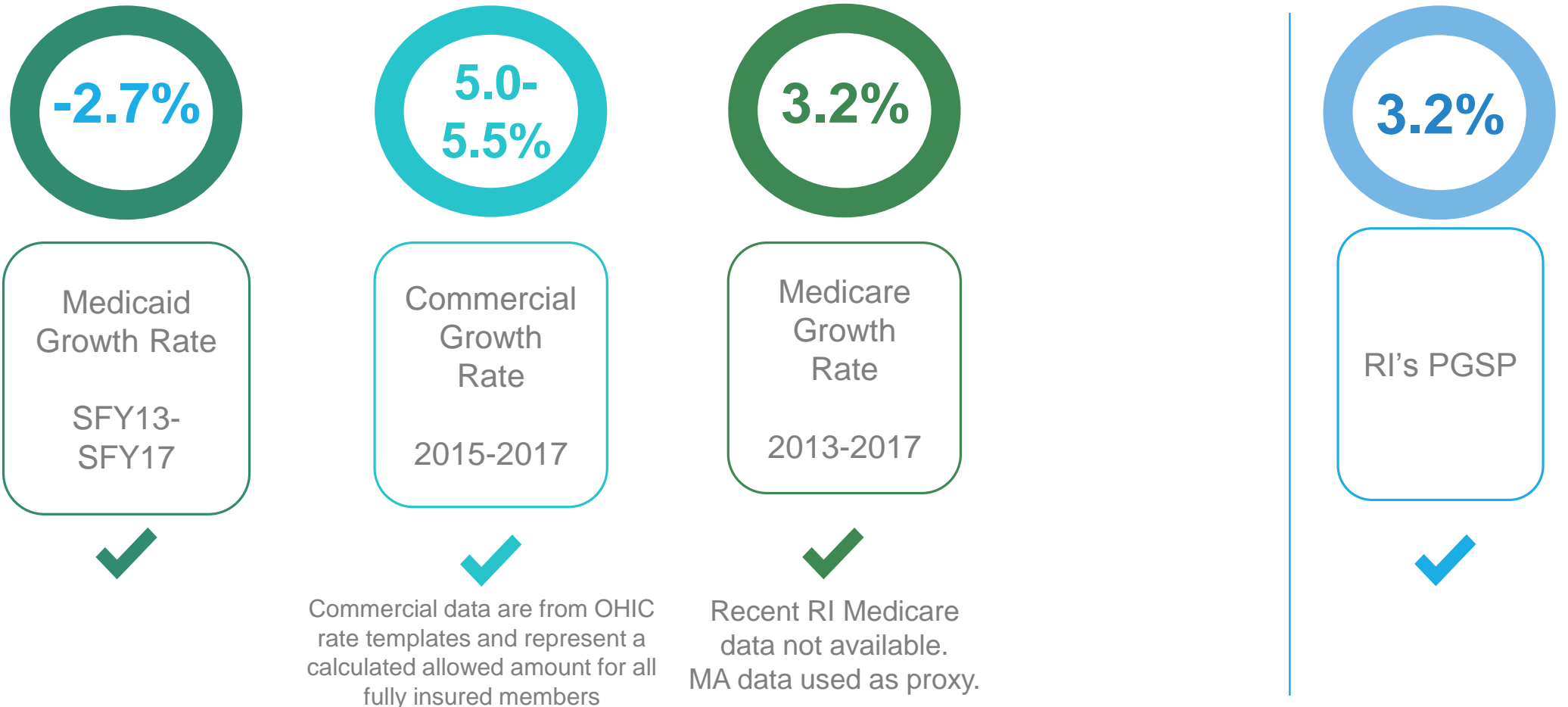
Sources:

Congressional Budget Office

RI Office of Management and Budget purchased forecasts from IHS Economics

Division of Statewide Planning

How Does RI PGSP Compare to Recent Cost Growth Trends?



RI PGSP in Context to OHIC Rate Caps and Massachusetts Cost Growth Target



OHIC
Hospital
Rate
Increase
Cap
2019



This rate is tied to
CPI-U Less Food
and Energy +1%

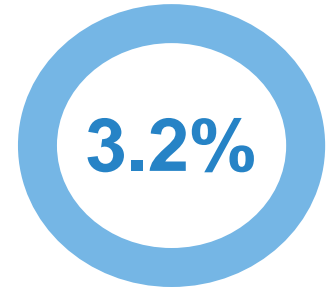


OHIC
ACO
Budget
Increase
Cap
2019



This rate is tied to
CPI-U Less Food
and Energy +1.5%

OHIC intends to
reassess these
caps during 2019



RI's PGSP



MA and DE Cost Growth Target Timing

Massachusetts' Approach

Year	Target
2013–2017	PGSP (3.6%)
2018–2022	PGSP – 0.5%
2023+	PGSP or another value, at the discretion of the Health Policy Commission

Delaware's Recommended Approach

Year	Target
2019-2023	PGSP calculated as of 2018*
2023+	Delaware Finance Advisory Committee can change methodology

*Annually the components of PGSP will be reviewed to determine whether they changed significantly enough to warrant a change in the state's cost growth target.

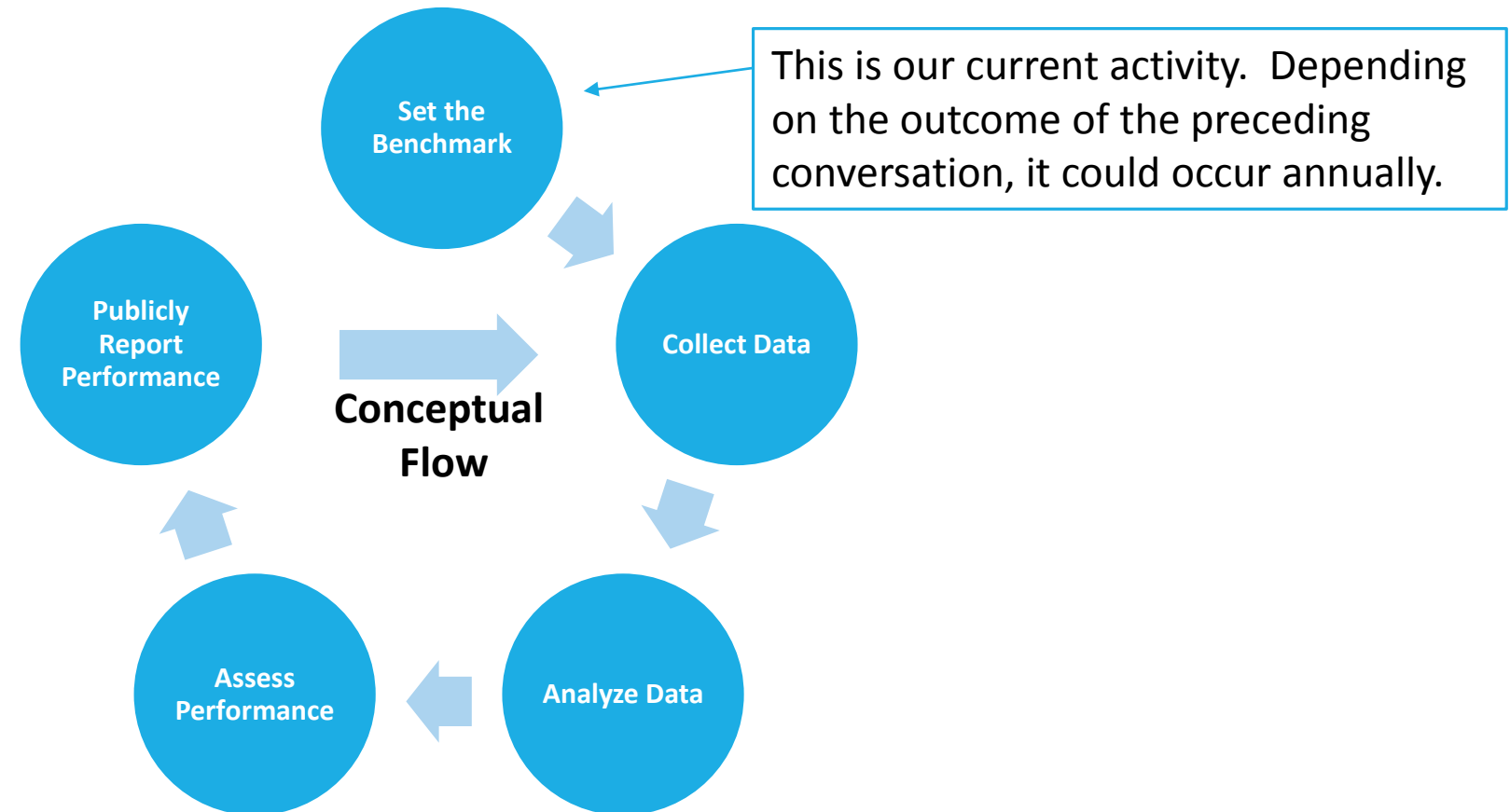
Cost Growth Target for 2019: Recommendation

1. Should PGSP for 2019 be adjusted? If so, how?
2. Should the target established for 2019 cover one or more years? If more, how many?
3. If the target is multi-year, should it change over time or be fixed?
4. Should there be a periodic review of the target setting methodology? If so, what should be its scope, and how often should it be performed?



Timeline for Implementing Target Policy Recommendations

This is the conceptual framework for target setting and performance assessment.



Estimated Cost Target Timeline



- **January 1:** Year 1 begins
- **November 1:** Year 2 cost target announced (*should it be different than 2019*)
- **December 31:** Year 1 ends

- **January 1:** Year 2 begins
- **Summer:** Data from Year 1 (2019) is received and performance review begins
- **Fall:** Year 1 performance announced
- **November 1:** Year 3 cost target announced (*should it be different than 2020*)
- **December 31:** Year 2 ends

- **January 1:** Year 3 begins
- Prior year process repeats...
- ...
- ...
- **December 31:** Year 3 ends

Cost Growth Target: Reporting Performance

Cost Growth Target: Reporting Performance

How should performance be reported? (e.g., publicly reported in a report, reported to a state entity, in a public hearing, etc.)

Massachusetts' Approach

Annually calculates performance against the benchmark and publicly reports performance. Performance is reported at the total state level, by market (commercial, Medicaid, Medicare) and by insurer. CHIA also produces data files with performance for the top 10 largest providers, but does not publish it with the same level of analysis as state, market and insurer level.

The Health Policy Commission holds annual hearings where state officials, payers, providers and stakeholders testify in front of the Commission.

- Hearings are well publicized, attended, streamed and recorded and bring health care leaders and stakeholders together to discuss the cost of the health care system.

This year's panel focused on access to timely primary and behavioral health, pharmaceutical spending growth and issues specific to a ballot initiative on nurse-patient ratios.

MA Reporting

10/22/2018

Growth in state health care spending drops to lowest level in five years - The Boston Globe

B Business & Tech

Growth in state health care spending drops to lowest level in five years



FILE PHOTO/GETTY IMAGES

Out-of-pocket costs, such as deductibles and co-pays, increased at a rate of 5.7 percent last year in Massachusetts.

By Priyanka Dayal McCluskey

GLOBE STAFF SEPTEMBER 12, 2018

CENTER FOR HEALTH INFORMATION AND ANALYSIS

PERFORMANCE OF THE MASSACHUSETTS HEALTH CARE SYSTEM

ANNUAL REPORT SEPTEMBER 2018



MASSACHUSETTS
HEALTH POLICY COMMISSION

DAY ONE

2018 Health Care Cost Trends Hearing

TUESDAY, OCTOBER 16, 2018 | 9:00 AM – 3:30 PM

9:00 AM	9:00 AM
9:15 AM	9:15 AM
9:30 AM	9:30 AM
10:00 AM	10:00 AM
10:15 AM	10:15 AM
11:15 AM	11:15 AM
12:30 PM	12:30 PM
1:15 PM	1:15 PM
2:30 PM	2:30 PM
3:30 PM	3:30 PM

Content and timing are subject to change leading up to the hearing. For more information, contact hpcc-info@mass.gov

Reporting Performance: Recommendation

1. How should performance be reported? (e.g., publicly reported in a report, reported to a state entity, in a public hearing, etc.)
2. Which entity will assess performance against the target and with what resources?



Public Comment Period

Wrap-Up and Next Meetings

All meetings are Mondays from 9:00 a.m.-12:00 p.m.

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|--------------------|---|
| November 26 | 301 Metro Center Blvd, Suite 203, Warwick, RI 02886 |
| December 10 | 301 Metro Center Blvd, Suite 203, Warwick, RI 02886 |
| January 14 | 301 Metro Center Blvd, Suite 203, Warwick, RI 02886 |
| February 11 | 301 Metro Center Blvd, Suite 203, Warwick, RI 02886 |
| March 11 | 301 Metro Center Blvd, Suite 203, Warwick, RI 02886 |
| April 8 | 301 Metro Center Blvd, Suite 203, Warwick, RI 02886 |
| May 13 | 301 Metro Center Blvd, Suite 203, Warwick, RI 02886 |
| June 10 | 301 Metro Center Blvd, Suite 203, Warwick, RI 02886 |

