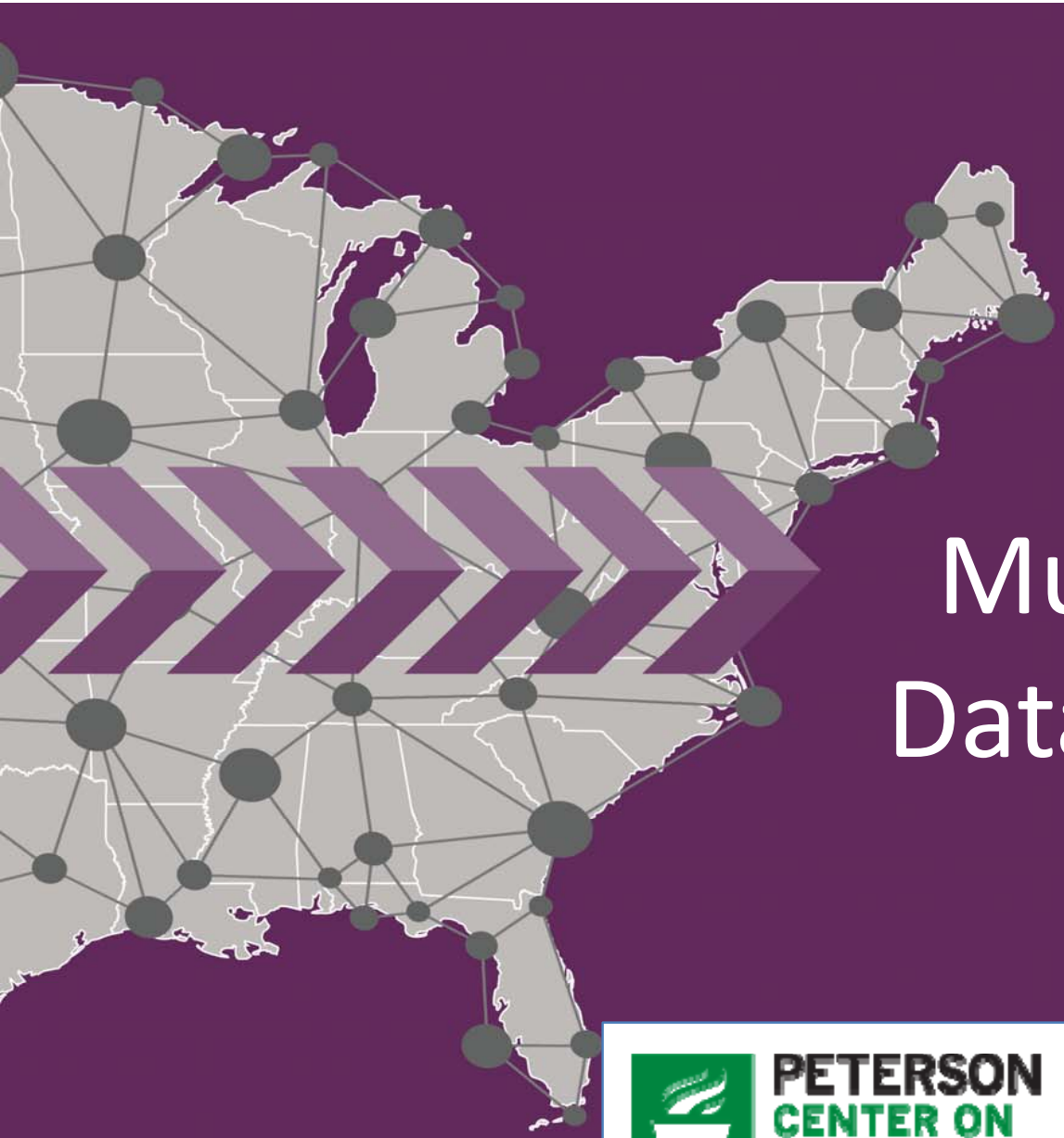

Leveraging Multi-Payer Claims Databases for Value

Bailit Health

March 27, 2019

PETERSON CENTER ON HEALTHCARE

STATE Health & Value STRATEGIES

Driving Innovation Across States

A grantee of the Robert Wood Johnson Foundation

Welcome

All participant lines are muted. If at any time you would like to submit a question, please use the Q&A box at the bottom right of your screen.

After the webinar, the slides and a recording will be available at **www.shvs.org**.

About State Health Value Strategies

State Health and Value Strategies (SHVS) assists states in their efforts to transform health and health care by providing targeted technical assistance to state officials and agencies. The program is a grantee of the Robert Wood Johnson Foundation, led by staff at Princeton University's Woodrow Wilson School of Public and International Affairs. The program connects states with experts and peers to undertake health care transformation initiatives. By engaging state officials, the program provides lessons learned, highlights successful strategies, and brings together states with experts in the field. Learn more at www.shvs.org.

Questions? Email Heather Howard at heatherh@Princeton.edu.

Support for this webinar was provided by the Robert Wood Johnson Foundation.
The views expressed here do not necessarily reflect the views of the Foundation.

Acknowledgments

- The information provided in this webinar was informed by the Rhode Island Health Care Cost Trends Project, which is funded by a grant from the Peterson Center on Healthcare to Brown University.
- The Rhode Island Healthcare Cost Trends Project is a collaboration of the Office of Governor Gina M. Raimondo, the Office of the Health Insurance Commissioner, and the Executive Office of Health and Human Services. They are working with Brown University's School of Public Health on a data-driven health care cost trend analysis.
- On November 14, 2018, the project hosted a conference to explore how states are leveraging multi-payer claims databases. Officials from Rhode Island and other states, national experts, and Rhode Island payers, providers, and consumer representatives discussed strategies for optimizing Rhode Island's all-payer claims database.
- Today we will hear from some of those speakers and from Marie Ganim, the Rhode Island Health Insurance Commissioner.

Webinar Presenters

- Erin Taylor, Senior Consultant, Bailit Health
- Mary Kate Mohlman, Health Services Researcher, Vermont Blueprint for Health
- Nancy Giunto, Executive Director, Washington Health Alliance
- Marie Ganim, Rhode Island Health Insurance Commissioner

Presentation Overview

1. Value of Claims Databases
2. Three Overarching Data Use Strategies
3. Developing a Data Use Strategy: Considerations for States
4. Use Case: Vermont Blueprint for Health
5. Use Case: Washington Health Alliance
6. Rhode Island's Approach
7. Discussion

Value of Claims Databases

- Multi-payer claims databases enable state to see health care system performance across payers
- Information from claims databases can be reported broadly and leveraged as a public resource to better understand operations and improve the health care system

Three Overarching Data Use Strategies

1. Support ongoing r**egulatory activity and analysis** of potential policy initiatives
2. Promote **transparency** for consumers and policymakers with cost and quality reporting and tools
3. Support specific **regional or provider-level delivery system** improvement activity

Developing a Data Use Strategy: Considerations for States

- Actively and continuously engage stakeholders
- Test data prior to release
- Circulate data and findings broadly
- Consider how state analysis should or could complement (and not duplicate) analyses occurring at provider and payer levels

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AGENCY OF HUMAN SERVICES

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Blueprint for Health
Smart choices. Powerful tools.

VERMONT
DEPARTMENT OF VERMONT HEALTH ACCESS

VHCURES
Data Use Cases for Vermont's All-Payer Claims Database

Mary Kate Mohlman, PhD, MS
Health Services Researcher, Blueprint for Health
Department of Vermont Health Access
March 27, 2019

Community and Health Practice Profiles

- Uses To Date:
  - Increasing data fluency and data-driven decision making
  - Quality improvement initiatives
  - Practice and regional priority setting
  - ACO priority setting
- Challenges:
  - Data timeliness
  - Ability to trend over time
- Future uses
  - Broader and deeper analyses on trend and association
  - Inform data uses for other entities such as ACOs

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Community Health Profiles

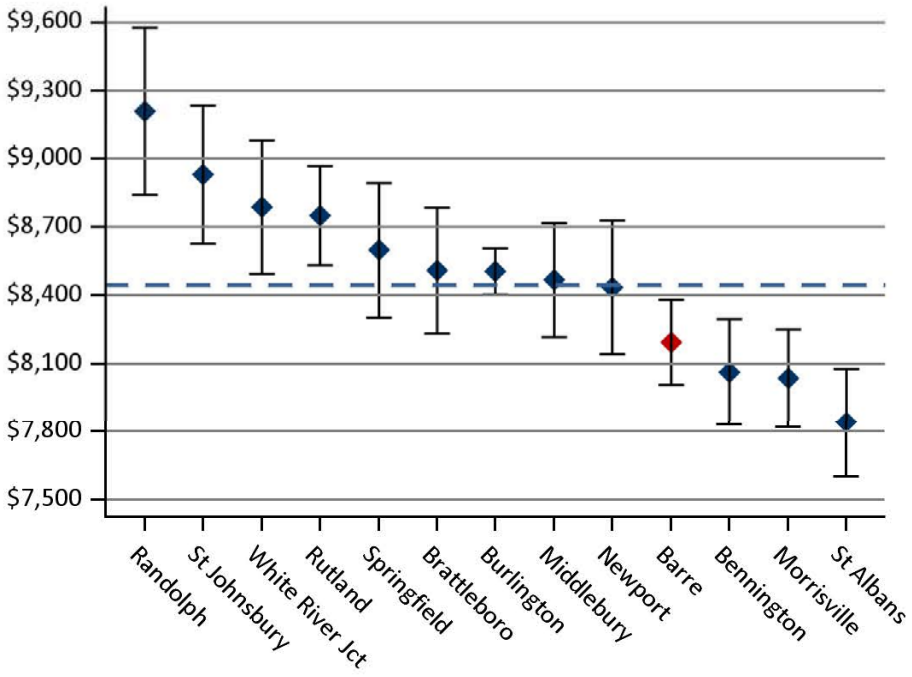
Demographics & Health Status

	HSA	Statewide
Average Members	23,120	229,377
Average Age	52.1	52.0
% Female	54.5	55.7
% Medicaid	18.8	23.1
% Medicare	32.5	34.1
% Maternity	6.8	7.1
% with Selected Chronic Conditions	44.7	43.1
Health Status (CRG)		
% Healthy	23.5	25.3
% Acute or Minor Chronic	14.4	14.7
% Moderate Chronic	26.5	26.7
% Significant Chronic	33.5	31.0
% Cancer or Catastrophic	2.0	2.2

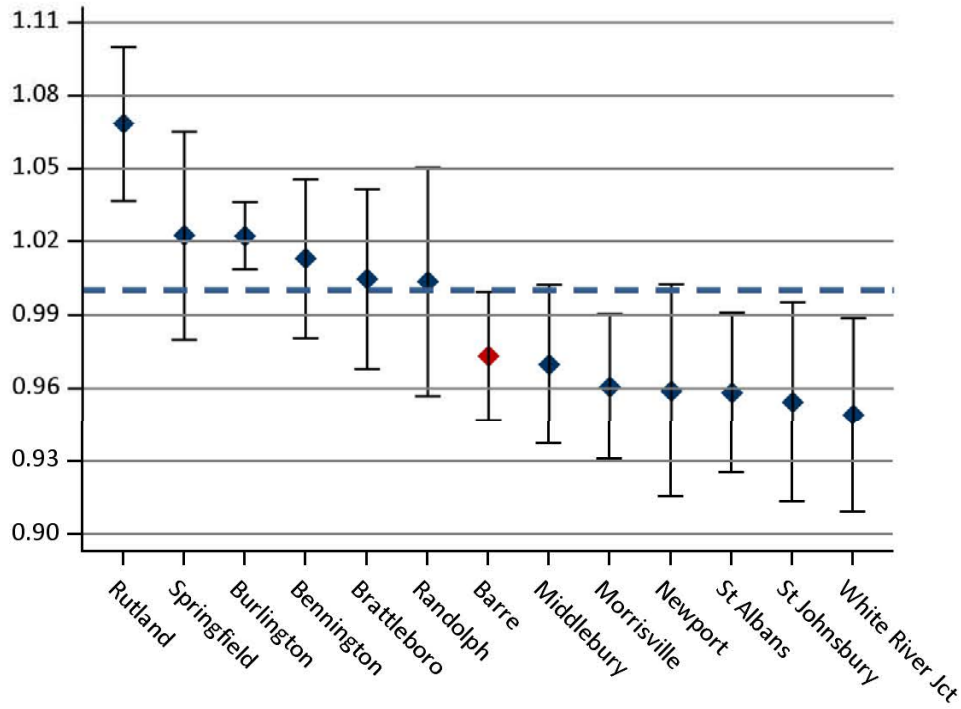
Table 1: *This table provides comparative information on the demographics and health status of the specified HSA and of the state as a whole. Included measures reflect the types of information used to generate adjusted rates: age, gender, maternity status, and health status.*

Community Health Profiles

Total Expenditures per Capita (Excluding SMS)



Total Resource Use Index (RUI) (Excluding SMS)

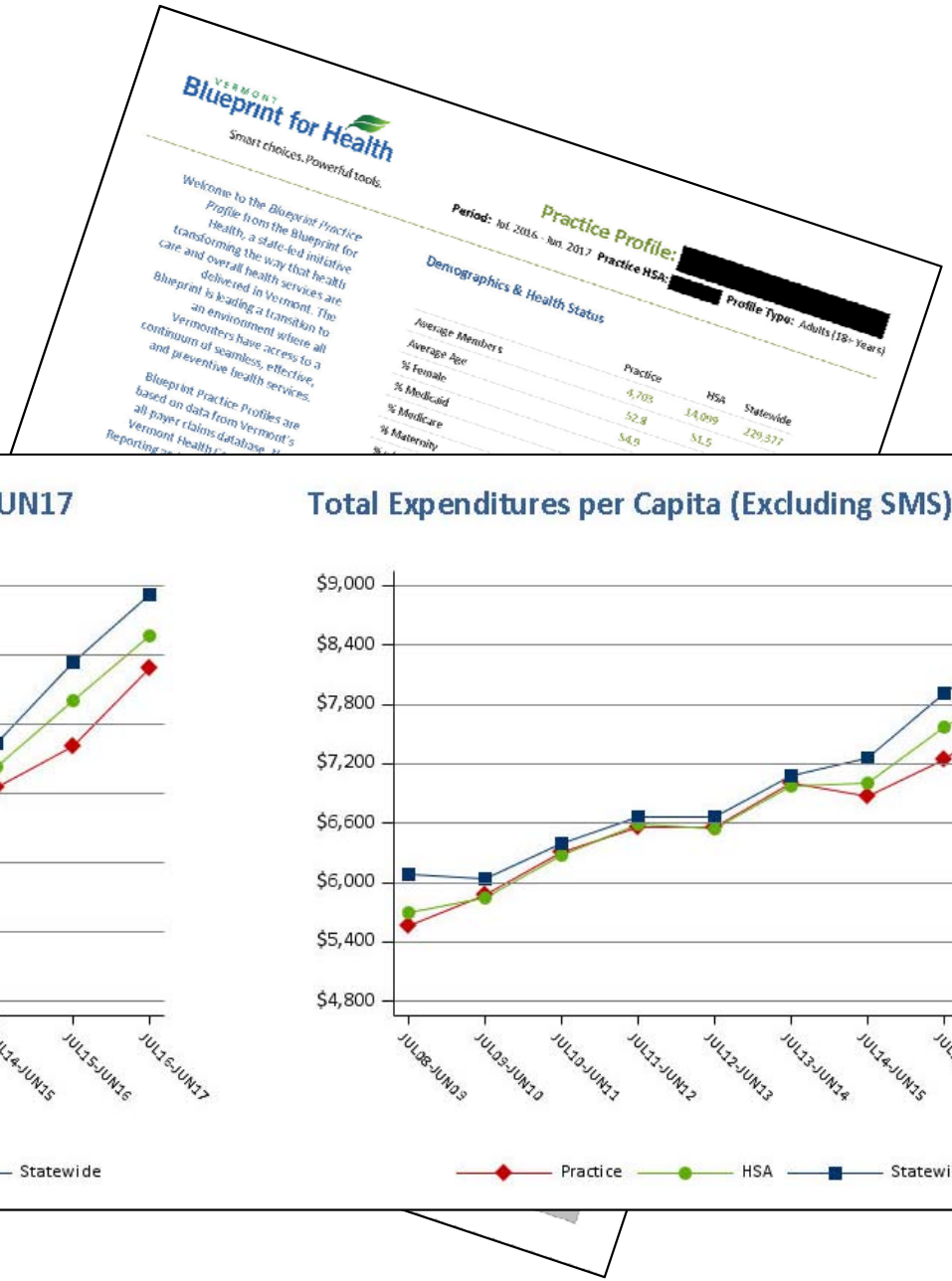


Community Health Profiles

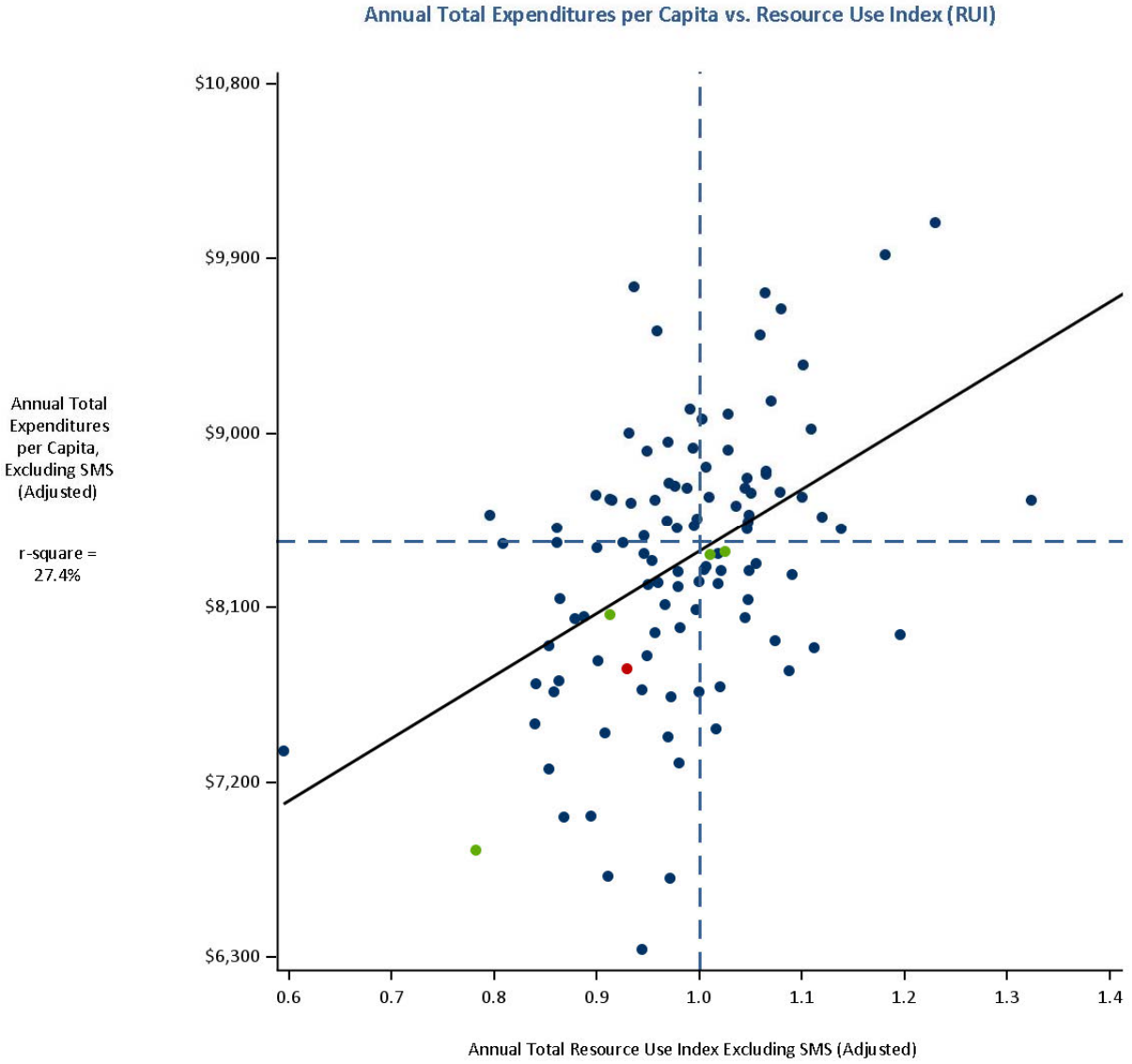
Linked Clinical Data: Obesity, Hypertension, & HbA1c

Measure (N = Count of distinct members)	HSA N=25,123	Statewide N=250,844
	Rate %	Rate %
% linked to clinical data	84%	54%
% with BMI data	69%	37%
% meeting obesity criteria	38%	39%
% with blood pressure data	79%	46%
% meeting hypertension criteria	16%	21%
% with BMI and blood pressure data	68%	37%
% meeting obesity and hypertension criteria	8%	10%
Measure (N = Count of distinct members with diabetes)	**HSA N=1,914**	**Statewide N=18,231**
	Rate %	Rate %
% linked to clinical data	93%	66%
% with BMI data	80%	47%
% meeting obesity criteria	72%	69%
% with blood pressure data	89%	55%
% meeting hypertension criteria	22%	28%
% with valid HbA1c	76%	43%
% with HbA1c >9%	10%	6%

Practice Profiles



Practice Profiles



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Washington Health Alliance:
Leading Health System
Improvement Since 2005

Leveraging APCDs for Value

State Health and Value Strategies Program
March 27, 2019

WASHINGTON HEALTH ALLIANCE
Leading health system improvement

Washington Health Alliance

- **14 year history.** Grassroots effort gave us our start in 2005.
- **Multi-stakeholder**. 185+ member organizations statewide representing health care purchasers, health plans, providers and other health partners.
- **Governed by a diverse, multi-stakeholder** board of directors
- **Purchaser-led.** The majority of our *governing* members represent employers and labor union trusts.
- **Non-profit.** We are a designated 501(c)3.
- **Non-partisan.** We engage in lobbying efforts on a very limited basis and only on topics that are directly related to our mission and core work.
- Started in Puget Sound, **expanded statewide in 2013**.

Alliance: Two Main Functions

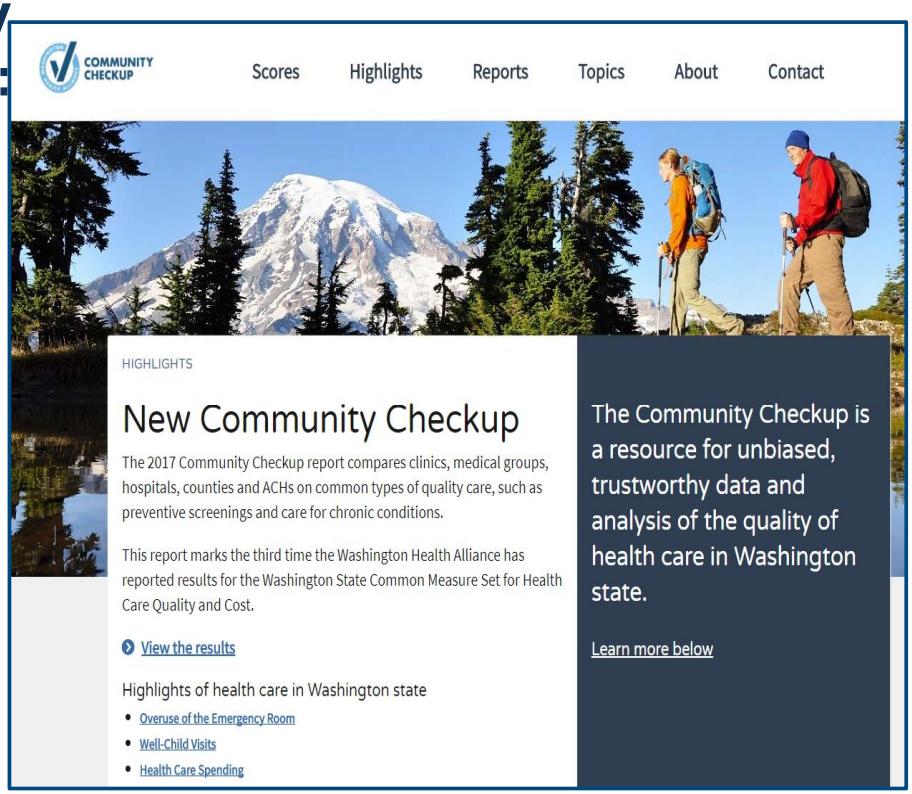
We are a trusted convener for stakeholders, promoting a collective conversation to transform care delivery and financing.

Performance measurement and reporting is a core competency of the Washington Health Alliance.

The Community Checkup

www.wacommunitycheckup.org

Results shared publicly via our website:



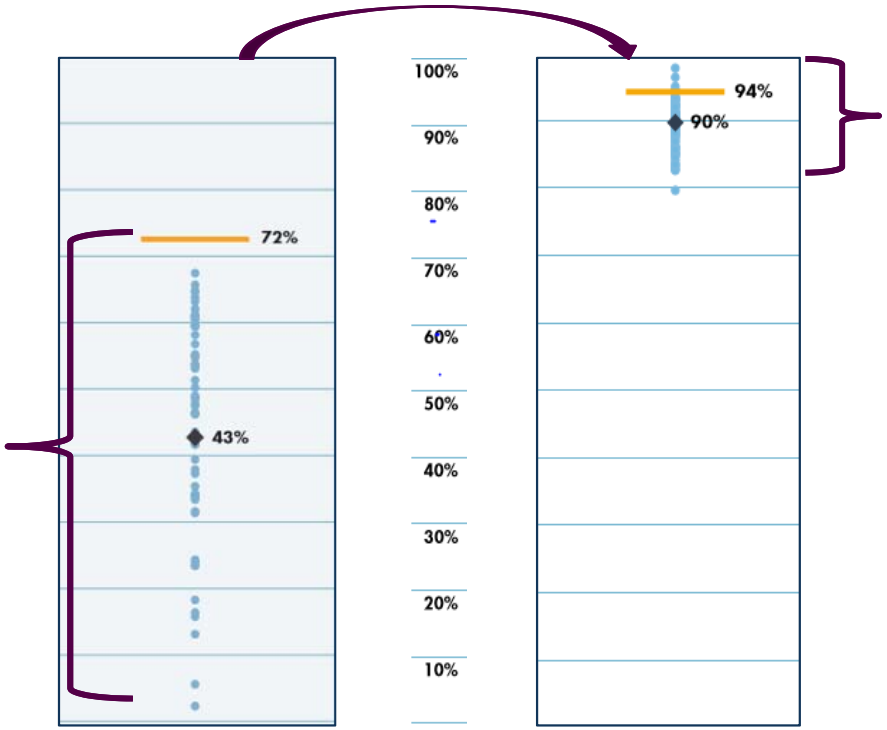
By written report:

Focusing on Variation in Health Care on All Important Measures of Quality:

We want to go from this:

To this:

Wide variation in performance around the mean and considerable distance between the state average and national 90th percentile



Much narrower variation in performance around the mean and minimal distance between the state average and national 90th percentile

Variation in health care by medical group

Type of Care	State Average	Highest Performing Medical Group		Lowest Performing Medical Group
Eye exams for people w/ diabetes	72%	95.6%	53	42.7%
Blood sugar testing for people w/ diabetes	89%	95.6%	32	63.6%
Managing meds for people w/ asthma	45%	61.5%	27	34.4%
Monitoring patients on high blood pressure meds	79%	93.9%	32	61.9%
Statin therapy for patients w/CVD	78%	87.1%	15	71.9%
Staying on anti-depressants for 6 months	54%	64.0%	20	44.0%
Avoiding antibiotics in adults with acute bronchitis	41%	68.2%	44	24.5%
Avoiding imaging for low back pain during first six weeks	79%	90.5%	36	54.5%

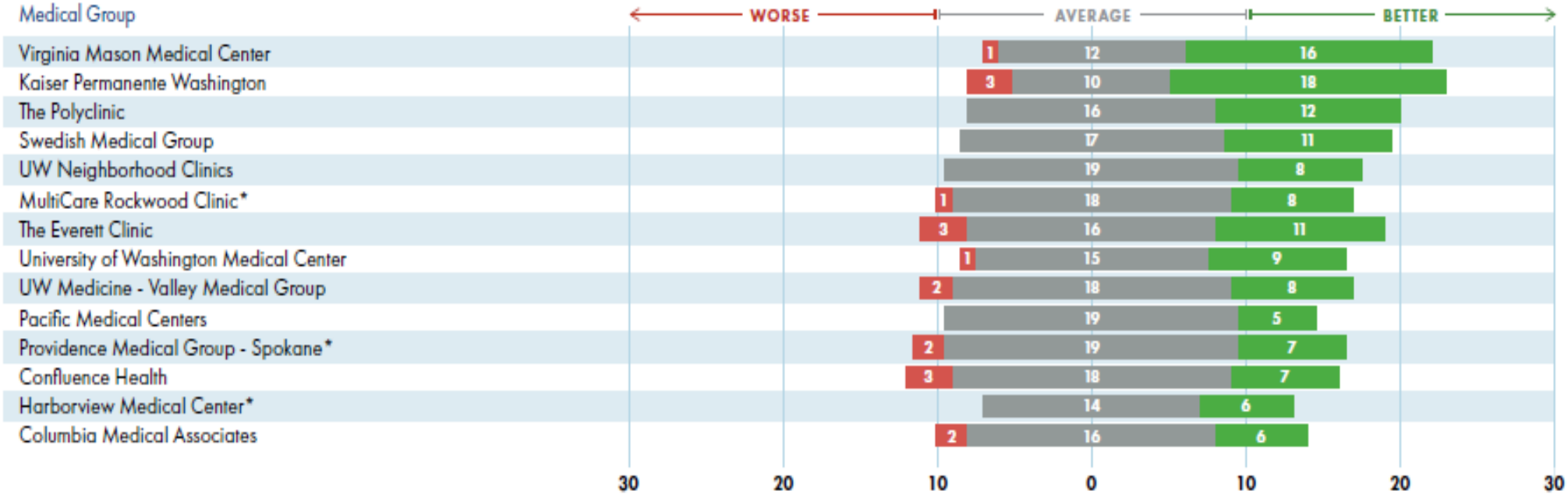
Variation in health care by county

Type of Care	State Average	Highest Performing County		Lowest Performing County
Access to Care (7-11 years old)	82%	90.1%	25	64.6%
Access to Care (12-19 years old)	84%	93.6%	29	64.6%
Vaccinations by Age 13	30%	44.2%	39	5.7%
HPV Vaccination Boys	29%	44.0%	33	10.8%
HPV Vaccination Girls	33%	47.1%	33	14.3%

Ranking Medical Group Performance

COMMUNITY CHECKUP

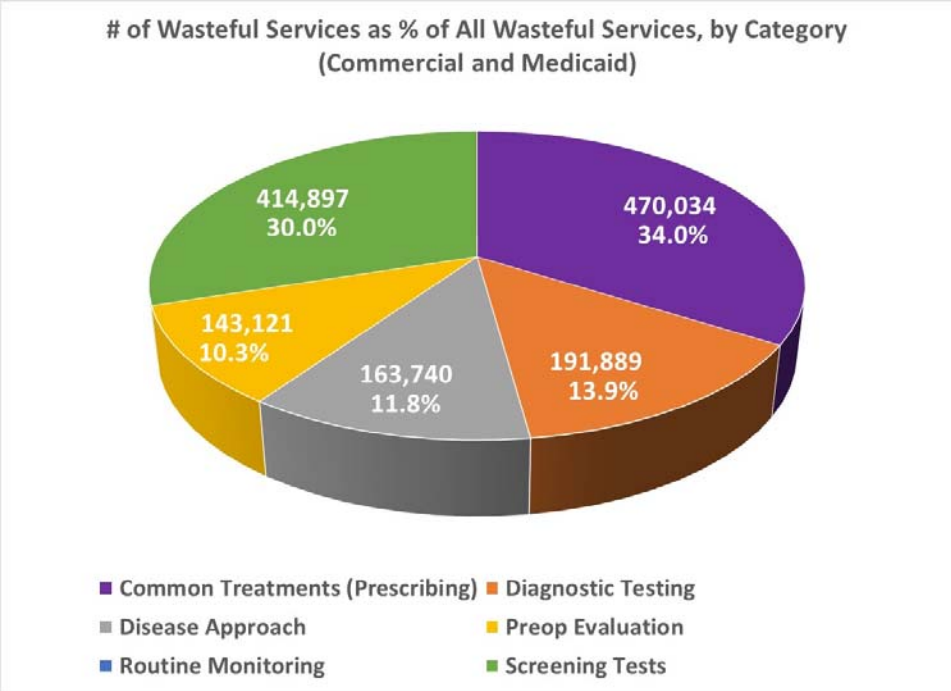
Figure 5: Ranking Medical Group Performance for **Commercially-Insured**: Medical Groups That Have Results for **15 or More** Measures



NEW Results from the Health Waste Calculator December, 2018

Wasteful Services by Measure Category (Commercial and Medicaid Combined)

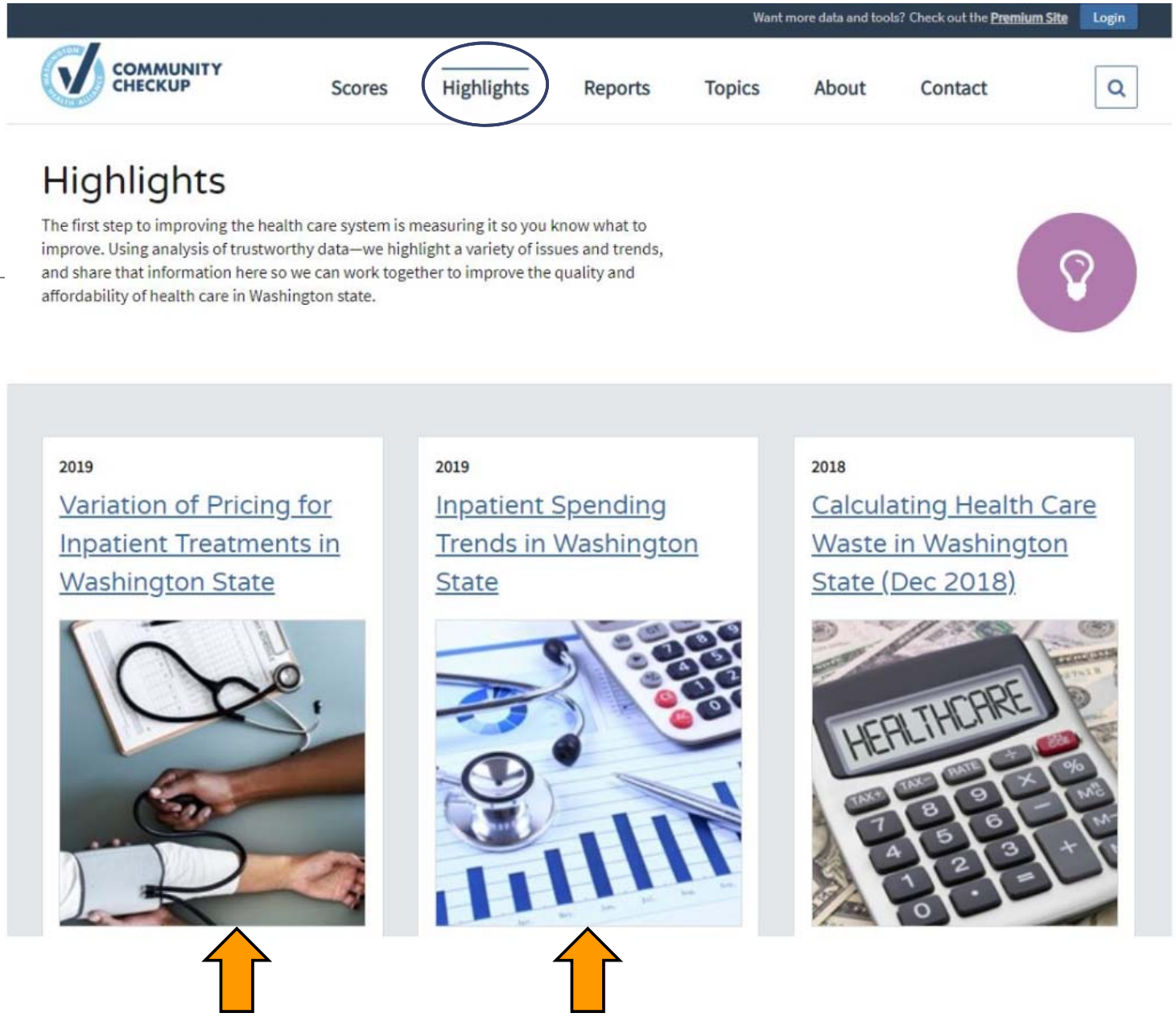
The 48 measures included in the Health Waste Calculator are grouped into six categories to organize results by types of care. Wasteful services in the Common Treatments (prescribing) and Screening Tests categories account for almost two thirds of all wasteful services measured in this analysis. The waste index varies considerably based on the category.



Category	# of Measures	Total # of Services Measured	Total # of Wasteful Services*	Waste Index*
Common Treatments	5	486,449	470,034	96.6%
Diagnostic Testing	19	320,095	191,889	59.9%
Disease Approach	11	592,976	163,740	27.6%
Pre-op Evaluation	4	230,152	143,121	62.2%
Routine Monitoring	1	39	39	100%
Screening Tests	8	1,304,815	414,897	31.8%
Total	48	2,934,526	1,383,720	47.2%

*Includes Likely Wasteful and Wasteful
Routine Monitoring (not included in chart above) = <1%

Where to find pricing reports



www.wacommunitycheckup.org/highlights

Price variation findings

Statewide results for 171 distinct inpatient treatments

Seven treatments account for **50%** of studied spending

- Among these, higher prices are 2.8 to 3.8 times greater than lower prices statewide
- Example: certain **spine fusion** treatments ranged from **$30,000-$118,000**, a 3.8 fold difference

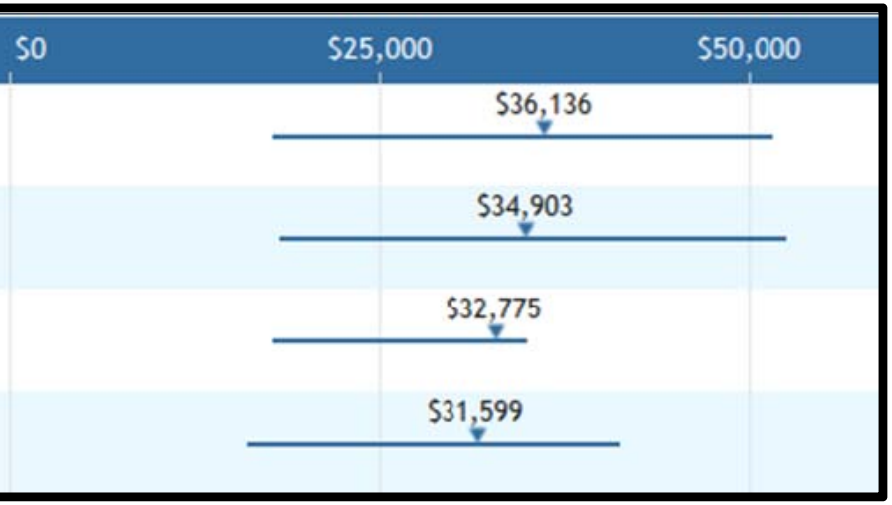
Between-hospital median prices show a similar degree of variation

Within-hospital case price variation can exceed statewide readings

Price variation by inpatient treatment

Admitting hospital, sorted by median price, with lower* and higher* prices defining the horizontal range

Hospital	Low	Median	High
SWEDISH MEDICAL CENTER	$17,703	$36,136	$51,603
VIRGINIA MASON MEDICAL CENTER	$18,150	$34,903	$52,562
VALLEY MEDICAL CENTER	$17,780	$32,775	$34,978
OVERLAKE HOSPITAL MEDICAL CENTER	$16,040	$31,599	$41,282



*Each price range represents the “middle 90%” of cases (5% most and least expensive cases have been removed)

WA prices for highest-spend treatments

Treatment (minor severity) Hospital & physician fees	**LOWER**	**MEDIAN**	**HIGHER**
1. Vaginal delivery	$6,451	**$11,060**	$18,947
2. Knee replacement	$15,910	**$30,759**	$51,749
3. Hip replacement	$16,405	**$31,988**	$50,631
4. Cesarean delivery	$9,576	**$16,459**	$28,285
5. Spine fusion - dorsal/lumbar	$30,897	**$60,620**	$118,375
6. Normal newborn	$1,336	**$2,495**	$4,789
7. Spine fusion - cervical	$19,370	**$37,634**	$68,747

Inpatient spending trend analysis

This inaugural report serves to demonstrate a technique for isolating and quantifying distinct spending drivers, using statewide data

Focus on employers wishing to conduct this analysis on their data

Spending trend: employer use case

Scenario:

Board of directors wants to know why inpatient costs rose last year. They want specifics:

"Is it our growth? Usage of healthcare? Complexity of treatments delivered? Price per unit of service?"

Directors want both big picture and treatment-specific explanations.

Not just hospital fees, but professional fees, too.

Four drivers of spending change

Two VOLUME-related drivers (e.g., the number of cases)

1. Membership

- Insuring more people drives spending up

2. Service Frequency

- Seeking care more often drives spending up

Two PRICE-related drivers (e.g., the price per case)

3. Service Intensity:

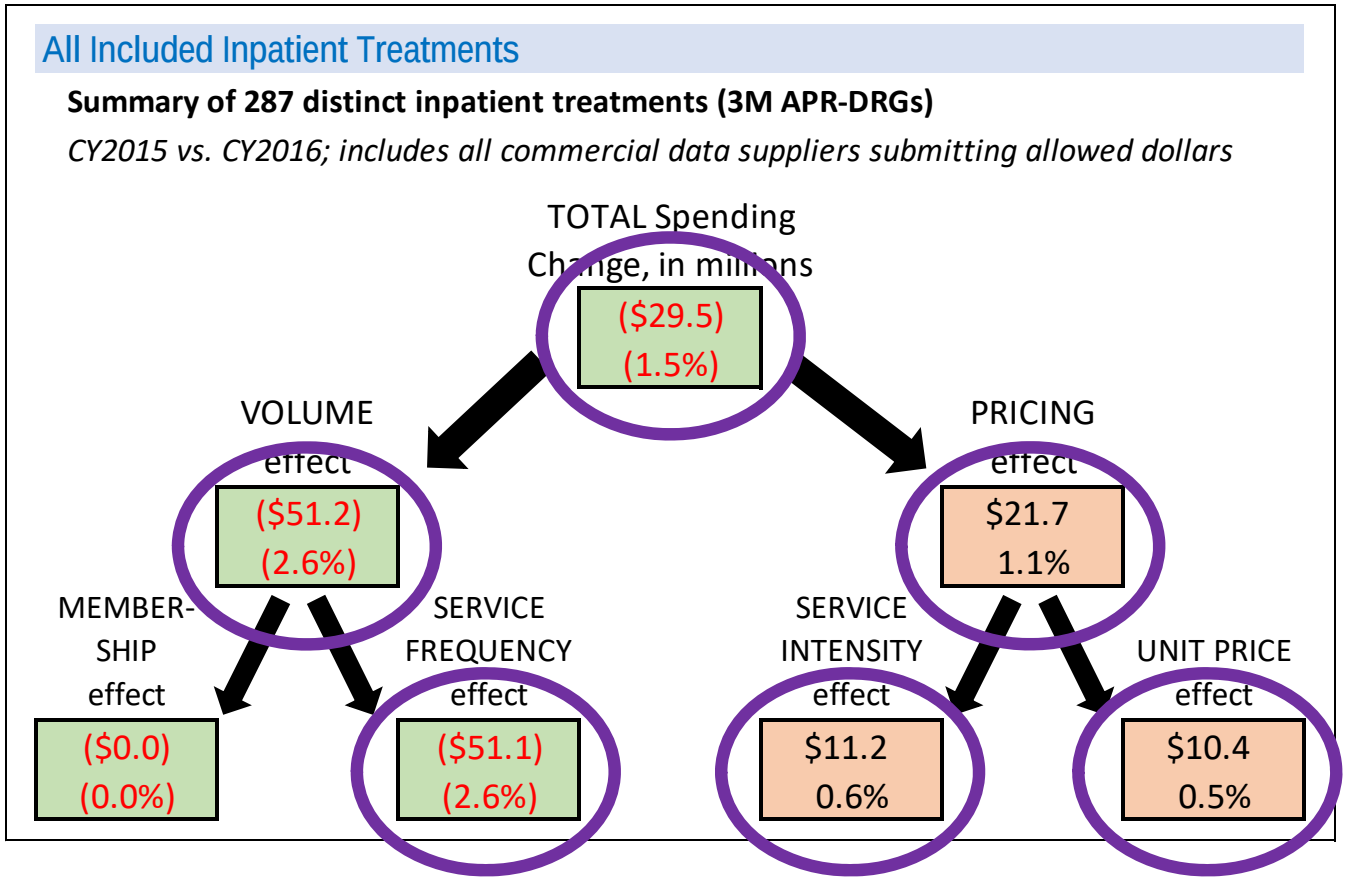
- More units of service to deliver care drives spending up (e.g., longer hospital stays, more technology, etc.)

4. Unit Price:

- Paying more for each unit of resource drives spending up

Big picture findings

Note: patterns/results will differ for individual employers!



Nancy A. Giunto, Executive Director

Washington Health Alliance

Rhode Island
Health Care Cost Trends Project

Marie Ganim

Rhode Island Health Insurance Commissioner

March 27, 2019

Health Care Cost Trends Project: Overall 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.

Health Care Cost Trends Project: Data Use Strategy

- With input from many stakeholders, we are developing a data use strategy to leverage RI's claims database – HealthFacts RI – *on an ongoing basis*
- The strategy will provide a plan for the design and production of reports to inform and drive health care system performance improvements

Stakeholder Engagement Process

- November 2018 Conference: Invited speakers discussed their experience and best practices in use of multi-payer claims databases to generate health care system value. Rhode Island stakeholders, including the project Steering Committee and other payers, providers, community organizations, discussed application of best practices and other data use approaches for Rhode Island.
- Provider Focus Groups: These were designed to obtain input on the types of analyses that would be valuable for clinicians and provider organizations.
- Steering Committee Meetings: The project's Steering Committee has been engaged in multiple discussions of strategic uses of RI's claims database.

Strategic Recommendations

- Discussions to date have led to draft recommendations for routine analyses of APCD data to be publicly reported.
- The recommendations call for analyzing the following and reporting variation by insurance coverage (e.g., commercial, Medicaid, Medicare), by provider and geography (as appropriate):
  - cost growth drivers;
  - low-value services;
  - population demographics, including social determinants of health;
  - price and cost variation by service and episode of care;
  - potentially-preventable services, and
  - quality of care.

Finalizing a Data Use Strategy

- The draft recommendations are currently posted for public comment
- Following the public comment period, the Steering Committee will review and discuss public comments.
- The project team – with input from the Steering Committee – will develop a revised strategy.
- The State will present the revised strategy at a stakeholder meeting in May 2019 and invite feedback.
- The Steering Committee will then finalize a data use strategy for implementation activity starting later in 2019.

Thank you!

Discussion

The slides and a recording of the webinar will be available at www.shvs.org after the webinar

Thank You

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