# Data Release Review Committee (DRRC)
# CO APCD Data Requests Summary
# Meeting: January 5, 2022

### 22.100.7 National Academy for State Health Policy (NASHP) - Health System's Physician Practice Acquisition Effect on Cost of Care

**Project Purpose:**

The National Academy for State Health Policy (NASHP) in partnership with Optumas as the analytic firm, requests access to CO APCD data to understand the impact health systems' acquisition of physician practices have on the cost of care. The primary focus of this study is to evaluate the impact on professional providers that are acquired by facilities over time. The intent is to quantify the difference before and after acquisition on charged amounts, member liability, and total allowed amounts.

**Specific Aims:**

1. As large hospital systems acquire and affiliate with physician practices, what is the financial impact to the health care system at large, as well as to consumers?
2. What value, or lack of value, does health system acquisition of physician practices add to the health care system?
3. Is there excess cost to the system that could be addressed through regulatory or legislative policy changes?

**Type of Data Requested:**

Limited Data Set

## 22.50 Duke University, supported by the Robert Wood Johnson Health Data for Action Grant- Examining Medicare Reliance after Implementation of Medicare Payment Reform and the ACA

**Project Purpose:**

Medicare's price setting strategies have potential to shape provider behavior. When Medicare prices are deemed too low, providers may close, stop caring for Medicare patients, or start to pursue other payer sources. Dialysis facilities, which care for patients with end-stage kidney disease (ESKD), are acutely impacted by changes in Medicare payment because Medicare offers near universal coverage for ESKD patients and has historically funded care for 90% of this patient population. Recent policy changes may have reportedly induced dialysis facilities to shift their payer mix – and thus patients' reliance on insurance coverage – away from Medicare, raising concerns about benefits and harms to patients and payers.

To date, there is no empirical evidence on whether dialysis facilities' shifts away from Medicare is being replaced with private insurance, or if specific types of patients are disproportionately affected by these changes. The US Renal Data System, the national registry for ESKD patients and providers, is limited in describing non-Medicare patients and revenue sources for dialysis facilities. All-payer data are necessary to fully describe the mix of insurance coverage among patients with ESKD on dialysis and to gather empirical evidence on the impact of changes in payer mix on patients' access to care, outcomes, and costs. We propose to use the Center for Improving Value in Health Care (CIVHC) data to identify patient-level insurance coverage information across Medicare, Medicaid, and private insurance.

**Specific Aims:**

We will address three questions related to dialysis patients in Colorado:

1. Did rates of Medicare and private insurance coverage among new ESKD patients change after federal policies impacting ESKD care payment and coverage?
2. What patient (e.g., demographic, clinical) and regional characteristics are associated with transition to enrollment in Medicare during the 1st year of incident ESKD?
3. Is patient's health insurance program associated with greater likelihood of home dialysis (modality of treatment that is less costly to providers and payers) and overall payments for dialysis within one year of initiation

**Type of Data Requested:**

De-Identified Data Set with Identifiable Finder File created by CIVHC and delivered to US Renal Data System; ultimate output provided to Duke University will be de-identifiable data

## 22.02 Harvard University: Job Mobility as a Determinant of Risk Selection in Health Insurance: Evidence from Colorado's ACA Marketplace

*Original DRRC Review: 11/03/2021*

**Project Purpose:**

The private health insurance market in the U.S. has a distinctive feature that workers' coverage is predominantly tied to employment, and in fact, to their respective employers. According to my analysis of the American Community Survey (ACS) data, among the non-elderly population with private health insurance, employer-sponsored health insurance (ESHI) is by far the primary source, accounting for over 85% of coverage between 2008 and 2019. Given its significance, economists and policymakers have been concerned about "job-lock", a phenomenon in which insurance provision by employers distorts job mobility of workers.

This project aims to study the compounding impacts of the Affordable Care Act (ACA) of 2010 on job mobility and the stability of the individual health insurance market. Given that the ACA created health insurance marketplaces (HIMs) and provided generous subsidies to purchase insurance, an important research question is whether the law contributed to improvements in job mobility.

**The goals of this project are:**

(1)    to examine if there is causal evidence to support hypothesized mechanisms that link labor and insurance markets

(2)    to comprehensively research the welfare impacts of the establishment of ACA marketplaces, which incorporate both its value in providing health insurance to people and potential benefits in enhancing labor market mobility (with implications for workers' income and career trajectories).

Together, this research and analyses will provide a framework to analyze the factors determining the robustness of individual health insurance markets and how people react to policy changes through their insurance and job choices. This framework promises to be informative to Colorado policymakers as they weigh different policy options to continue providing affordable health insurance to more people. CO APCD Data and street address are needed to generate household demographics, to include income and healthcare utilization, and is a factor in creating an economical model for my analysis.

**Specific Aims:**

1. What are the impacts of the ACA on job mobility in Colorado?
2. How do changes in job mobility post-ACA (if any) in turn affect risk pooling on the Connect for Health Colorado marketplace?
3. How can the design of rating areas affect negotiated service prices, premiums, and patients' choices of providers and plans?

**Type of Data Requested:**

Identifiable Data Set

# 22.46 Signify Health: Provider Level Price and Quality Transparency to Benefit the State Employees of Colorado

*Original DRRC Review: 12/1/2021* **Project**

**Purpose:**

Signify's goal is to create a competitive market around episodes of care contracts, engaging providers to decrease high prices for routine procedures and treatments, rates of avoidable events/complications, use of low-value care services and volume of unnecessary procedures. We succeed by establishing partnerships with healthcare organizations (such as payers, hospitals, and physician groups) and providing them with operational and software solutions to improve quality and reduce episode costs.

The suite of clinical decision and performance reporting tools provided by Signify establish transparency about cost and quality performance within an episode of care, allowing providers and their patients the ability to make more informed, value-based health care decisions. Our screening quality criteria include but are not limited to:

- AAE (Actionable Adverse Event) rates which are adjusted for patient characteristics
- Leapfrog scores for specific procedures (e.g. Maternity) and overall patient safety score
- Overuse of low value services rate adjusted for patient characteristics ● Frequency of procedures for the management of conditions ● Mortality rates for complex procedures.

Signify supports providers in care transitions, potential complex care management and SDOH assessments to close care and social gaps of plan members. For any given condition or procedure, there are high-value providers. All providers will be assessed on measurable quality of care and episode price. On-going scorecards will help monitor improvements and provide critical feedback. Signify fully integrates with plans to reduce provider and member friction and encourages consistent messaging to plan members. Within the program, at-risk contracts are created with targeted physicians and facilities.

By identifying these high value providers in the state, residents will be able to make a more informed decision about their next site of care, identifying a provider that will provide higher quality for a lower price. This transparency will also reveal how some providers are able to achieve the same level of quality at a more affordable price. Overall patient experience can be improved if the patient is well-informed. Creating transparency for the resident removes the veil of mystery behind who they should and should not entrust their care to. Providing Colorado residents with evidence-based reports on the providers in their area will help to steer them to the best quality of care. In this particular project, the patients who would benefit from this program would be the Colorado State Employees.

The Colorado State Employee Plan uses the Colorado Purchasing Alliance for value-based care initiatives. Signify will do an analysis on behalf of the Colorado Purchasing Alliance wherein data provided by the State Employee Plan will be combined with the Colorado APCD data to create a more comprehensive and robust dataset that will (1) aid in developing more accurate episode prices, (2) increase sample size to

assess true historical provider performance and (3) reveal the opportunity available at the provider level to drive improved performance.

For this project, Signify is requesting CO APCD, limited to following identifiers:
- Age or year in which service was provided only // (no DOB)
- Provider zip only
- Limited to the episodes reference in the application supplement
- Commercial LOB only (No Medicare FFS or Medicaid)

**Methodology**

The analytic sample will include any individual with at least one episode of care. Episodes will be identified from Signify's episode grouper software (Prometheus definitions used to assign services to episodes) which relies on the combination of diagnostic and procedure codes on member claims to trigger episodes and assign relevant services.  All episodes will be attributed to either the operating surgeon (if a procedure) or the provider accounting for the plurality of office visits (if a condition).  Procedure episodes will also be attributed to the facility where it was performed.  Costs will be defined as the sum of payments for services assigned to an episode. Analyses will examine cost metrics at the total episode level and within sub-groupings, such as different types of care (radiology, office visits), site of care (inpatient vs outpatient), and phase (pre-operative, intra-operative, and post-operative).  Quality will be measured based on Signify's Avoidable Actional Event (AAEs) definitions, which constitute complications that occurred during a particular episode which could have been avoided with optimal care. All analyses will be conducted separately for each population in the data (commercially insured).  Any provider-level analyses or reports produced from the data will be risk-adjusted to account for potential differences in patient case-mix.

**Type of Data Requested:**
Limited Data Set

## 20.55 University of Illinois at Chicago – Reuse Application: The Role of Health Insurance in Utilization, Costs, and Health

*Original Application Approved by DRRC 06/03/2020: Spending and Utilization for Insured Coloradans*

### Project Purpose:

The purpose of this project is to understand how insurance type and insurance design affect health care use, health care costs, and health outcomes in Colorado. The project will involve studying how enrollees' health care use, health care prices/costs, and health outcomes differ based on the health insurance coverage they have.

### Specific Aims:

How do health insurance type and design affect health care use, health care prices/costs, and health? Examples of insurance characteristics that I hypothesize might matter include the use of prior authorization requirements and utilization review, copayments, coinsurance, deductibles, provider networks, and health maintenance organizations. I hypothesize that Medicaid and Medicare are associated with lower health care costs than private insurance, both because Medicaid and Medicare pay lower reimbursements to providers and because providers respond to the lower reimbursements by reducing health care provided.

### Type of Data Requested:

n/a – request is to expand research questions