OFFICE OF THE
HEALTH INSURANCE COMMISSIONER
STATE OF RHODE ISLAND
AND PROVIDENCE PLANTATIONS

RI Health Care Cost Growth Target: Payer Technical Implementation Briefing

AUGUST 18, 2021

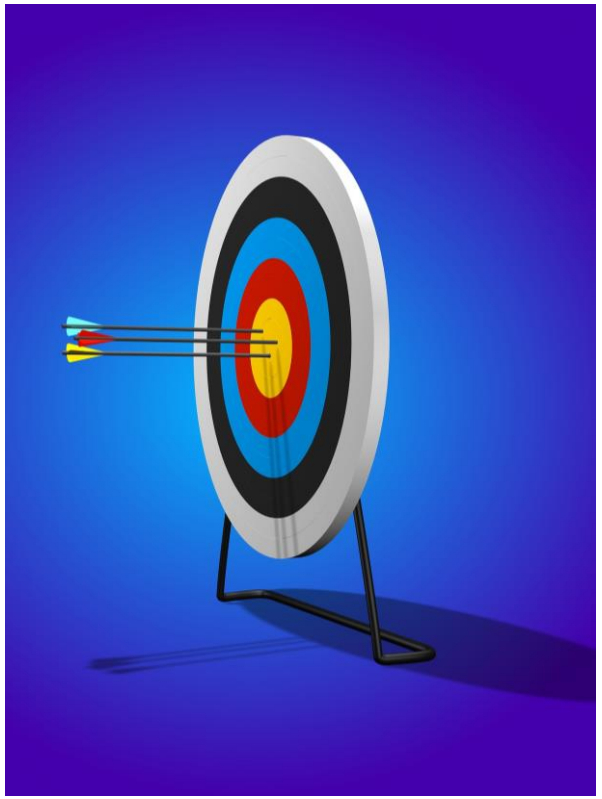
Technical Briefing Agenda

Welcome and Introductions	2:00 pm – 2:05 pm
Overview of Health Care Cost Growth Target, Primary Care Spend Obligation, and Methodological Updates	2:05 pm – 2:10 pm
Updates to Cost Growth Target Reporting Requirements	2:10 pm – 2:30 pm
Updates to Primary Care Spend Obligation Reporting Requirements	2:30 pm – 2:45 pm
Data Submission Process and Timeline	2:45 pm – 2:50 pm
Questions	2:50 pm – 3:00 pm

Overview of the Health Care Cost Growth Target, Primary Care Spending Obligation, and Methodological Updates

Refresher:
What Is a Health Care Cost Growth Target?

- A health care cost growth target (Target) is a per annum rate-of-growth target for health care costs in Rhode Island.
- The Rhode Island Cost Trends Steering Committee established the methodology, resulting in the signing of a voluntary compact between Committee members, including leaders of BCBSRI, NHPRI, Tufts and UnitedHealthcare.
- Governor Raimondo established the target as **3.2 percent** for 2019-2022 in Executive Order 19-03 in February 2019.



Refresher: What Is the Primary Care Spend Obligation?

- OHIC's Affordability Standards, per RICR-20-30-4, directs commercial insurers to spend at least **10.7 percent** of their annual medical expenses for all **fully insured lines of business** (LOB) on **primary care**, **9.7 percent** of which shall be for **direct primary care expenses**.
  - **Direct primary care**: all claims-based and non-claims-based primary care payments, excluding HIE payments for CurrentCare and PCMH administration payments to support the operations of CTC-RI
  - **Indirect primary care**: all HIE payments for CurrentCare and PCMH administration payments
- Insurers submit two reports to OHIC annually – a spring report with preliminary performance and a fall report with final performance.

Overview of Methodological Updates

- Updated definitions to the total medical expense service categories.
- New payer request to include “fees from uninsured plans” to calculate the net cost of private health insurance.
- Implementation of new methodologies for assessing benchmark performance, including truncation of spending for high cost outliers, the development of confidence intervals for trend, and risk-adjustment using age/sex factors.
- Combined data request for the primary care spend obligation with the cost growth target data request.

Changes to the Implementation Manual's Organization

- The Implementation Manual has been streamlined to indicate defining specifications for TME in one place.
- The manual also includes call-outs to indicate items of particular interest.

Denotes new specifications for CY 2020

Denotes specific instructions that insurers should take note of

Denotes when primary care spend obligation specifications differ from cost growth target specifications

Updates to Cost Growth Target Reporting Requirements

No Change in the Definition of Total Medical Expense

There are two figures being measured, both on a per capita basis:

1. **Total Medical Expense (TME)** incurred by Rhode Island residents for all health care services by all payers reporting to OHIC, regardless of where the care was delivered.
2. **Net Cost of Private Health Insurance (NCPHI):** Measures the costs to Rhode Island residents associated with the administration of private health insurance (including Medicare Advantage and Medicaid Managed Care). It is defined as the difference between health premiums earned and benefits incurred. It consists of insurers' costs of paying bills, advertising, sales commission and other administrative costs, premium taxes and profits (or contributions to reserves) or losses.

TME + NCPHI = Total Health Care Expenditures (THCE)

No Changes to General TME Specifications

- TME includes **claims** and **non-claims payments** for a single calendar year.
  - Non-claims payments are payments to providers not associated with a claim and include capitation payments, pay-for-performance bonuses, risk settlements, care management payments, etc.
- TME is to be reported based on **allowed amounts** (i.e., the amount the insurer paid plus any member cost sharing).
- TME is to be reported only for members who are **residents of RI** and for whom the insurer is primary on a claim.

Updates to TME Claims Category Definitions

- **Hospital inpatient**: Unchanged
- **Hospital outpatient**: Unchanged
- **Professional, primary care**: Updated definition to "TME paid to primary care providers delivering care at a primary care site of care generated from claims."
  - ***Primary care provider***: family practice, geriatric, internal medicine and pediatric providers, defined using specific taxonomy codes (see **Appendix F**).
  - ***Primary care site of care***: a primary care outpatient setting (e.g., office, clinic or center), federally-qualified health center, school-based health center, or via telehealth. Does not include stand-alone telehealth vendors.
  - ***Primary care services***: care management; care planning; consultation services; health risk assessments, screenings and counseling; home visits; hospice/home health services; immunization administrations; office visits; preventive medicine visits, defined using specific codes (see **Appendix G**).

Updates to TME Claims Category Definitions (Cont'd)

- **Professional, specialty care**: Updated to specify that specialty care physicians include doctors of medicine or osteopathy in clinical areas other than those specified in the "professional, primary care" spending category.
- **Professional, other**: Updated to include services delivered through third-party telehealth vendors contracted directly through the health plan to offer a subset of services.
  - No longer includes facility fees for community health services and freestanding ambulatory surgical centers (moved to Other).
- **Retail pharmacy**: Updated spending category name and to specify that it ***does not*** include the cost of vaccines administered in the primary care setting.

Updates to TME Claims Category Definitions (Cont'd)

- **Long-term care**: Updated definition to "TME data from claims to providers for: (1) nursing homes and skilled nursing facilities, (2) intermediate care facilities for individuals with intellectual disability and assisted living facilities and (3) providers of HCBS services.
  - No longer includes hospice or home health care services (moved to Other).
- **Other**: Updated to include facility fees of community health centers, free standing ambulatory surgical center services, hospice facility, hospice, and the cost of vaccines administered in the primary care setting.

Updates to TME Non-Claims Category Definitions

- All non-claims categories are ***new*** for reporting in 2021.
- **Prospective capitated, prospective global budget, prospective case rate, or prospective episode-based payments**: All non-claims based payments for services delivered under the following payment arrangements: (1) capitation payments, (2) global budget payments, (3) case rate payments, and (4) prospective episode-based payments.
- **Performance incentive payments**: All payments to reward providers for achieving quality or cost-savings goals, or payments received by providers that may be reduced if costs exceed a defined pre-determined, risk-adjusted target. Includes pay-for-performance, pay-for-reporting, shared savings distributions, and shared risk recoupments.

Updates to TME Non-Claims Category Definitions (Cont'd)

- **Payments to support population health and practice infrastructure**: All payments made to develop provider capacity and practice infrastructure to help coordinate care, improve quality and control costs (e.g., care management, care coordination and population health, EHR/HIT infrastructure payments and other data analytics payments, HIE payments, PCMH administration payments, PCMH recognition payments, and behavioral health integration not reimbursable through claims).
- **Provider salaries**: All payments for salaries of providers who provide health care services not otherwise included in other claims and non-claims categories. This category is typically only applicable to closed delivery systems.

Updates to TME Non-Claims Category Definitions (Cont'd)

- **Recoveries**: All payments received from a provider, member/beneficiary or other payer, which were distributed by a payer and then later recouped due to a review, audit or investigation.
  - This can include infrastructure payments that are recouped under TCOC arrangements if a provider does not generate savings.
- **Other**: All other payments made pursuant to the insurer's contract with a provider not made on the basis of a claim for health care benefits/services and cannot be properly classified elsewhere (e.g., governmental payer shortfall payments, grants, surplus payments, supportive funds made to providers to support clinical and business operations during the global COVID 19 pandemic). Does **not** include insurer administrative expenditures.

New Request for NCPHI Data

- OHIC requests insurers to report aggregate information on the premiums earned from their self-insured accounts (e.g., “fees from uninsured plans”).
- Insurers should follow the instructions for Part 1, Line 12 on the NAIC SCHE for their Rhode Island situs self-insured accounts.

Methodological Updates to Improve Target Performance Assessment

- Analysis of first-year performance data revealed the extent of the impact that high-cost outliers and changes in risk scores had on cost trends performance at the insurer and ACO/AE levels.
  - Because reporting performance results is performed, in part, for accountability purposes, we want to appropriately account for and acknowledging the impact of those factors.
- The Steering Committee members approved three methodological changes that will allow us to confidently assess and report performance at the insurer and provider levels.
  1. Use of a consistent risk-adjustment model across all payers and ACO/AEs.
  2. Truncation of spending for high-cost outliers.
  3. Calculation of confidence intervals around performance.

1. Application of Standardized Age/Sex Risk-Adjustment

Risk-Adjustment Methodology: Update

- Starting in CY 2020, measurement of insurer and ACO/AE performance against the Target will be risk-adjusted by age and sex, rather than by using diagnosis-based risk scores.
  - Age/sex risk-adjustment would not be applied to measurement at the state and market levels.
  - The age/sex bands by which TME will be risk-adjusted are consistent across markets.
- Insurers will need to provide data by age/sex cells in the new **Age_Sex Factors – 2019** and **Age_Sex Factors – 2020** tabs.

Age/Sex Cells	
Female	**Male**
0-1	0-1
2-18	2-18
19-39	19-39
40-54	40-54
55-64	55-64
65-74	65-74
85+	85+

Applying Standard Age/Sex Risk-Adjustment

STANDARD SPECIFICATION

- Insurers submit a clinical risk score that represents overall risk of all members being reported by Insurance Category Code and by ACO/AE Organization ID.
- OHIC applies the insurer-supplied risk scores to calculated risk-adjusted TME.

NEW SPECIFICATION

- Insurers submit TME and member months data by age/sex cells.
- OHIC will calculate standard age/sex factors to be applied to each insurer and ACO/AE's spending data by Insurance Category Code.
- Insurers must still submit clinical risk scores so OHIC can monitor the impact of the methodological change.

2. Truncation of Spending on High-Cost Outliers

Truncating High-Cost Outlier Spending

- Starting in CY 2020, measurement of insurer and ACO/AE performance against the Target will remove spending above certain thresholds at the member level.
  - Truncation would not be applied to measurement at the state and market levels.
  - The thresholds vary based on market (e.g., commercial, Medicaid, Medicare).

Insurance Category Code	Definition	Per Member Truncation Point
1	Medicare & Medicare Managed Care (excluding Medicare/Medicaid Dual Eligibles)	$100,000
2	Medicaid & Medicaid Managed Care including CHIP (excluding Medicare/Medicaid Dual Eligibles)	$250,000
3	Commercial — Full Claims	$150,000
4	Commercial — Partial Claims, Adjusted	$150,000
5	Medicare Expenditures for Medicare/Medicaid Dual Eligibles	$100,000
6	Medicaid Expenditures for Medicaid Dual Eligibles	$250,000
7	Medicare/Medicaid Integrated Duals Product (as of CY 2019 this applies only to the NHPRI Integrity Product)	$250,000
8	Other	Consult with OHIC.

Data Needed to Apply Truncation

STANDARD SPECIFICATION

- Payers submit total aggregate spending by service categories (with some spending category modifications compared to previous years) of claims and non-claims data.

NEW SPECIFICATION

- For each Insurance Category Code, overall and by ACO/AE, payers also submit the following:
  - Total spending after applying truncation.
  - Total amount removed after applying member-level truncation of spending.
  - Count of members whose spending was truncated.
- OHIC will use truncated totals when applying risk-adjustment.
  - Data must be reported for each age/sex cell.

Specifications for Applying the Truncation

- Truncation is applied to the individual member's total spending.
  - Truncation is not applied separately to medical and pharmacy spending.
- For insurers reporting in Insurance Category 4 (Partial Claims, Adjusted), the member level truncation should be applied after estimates of carve-out spending have been made.
- If a member is attributed to more than one ACO/AE during the year, insurers should "reset the clock" for calculating total spending that is subject to truncation for each ACO/AE.

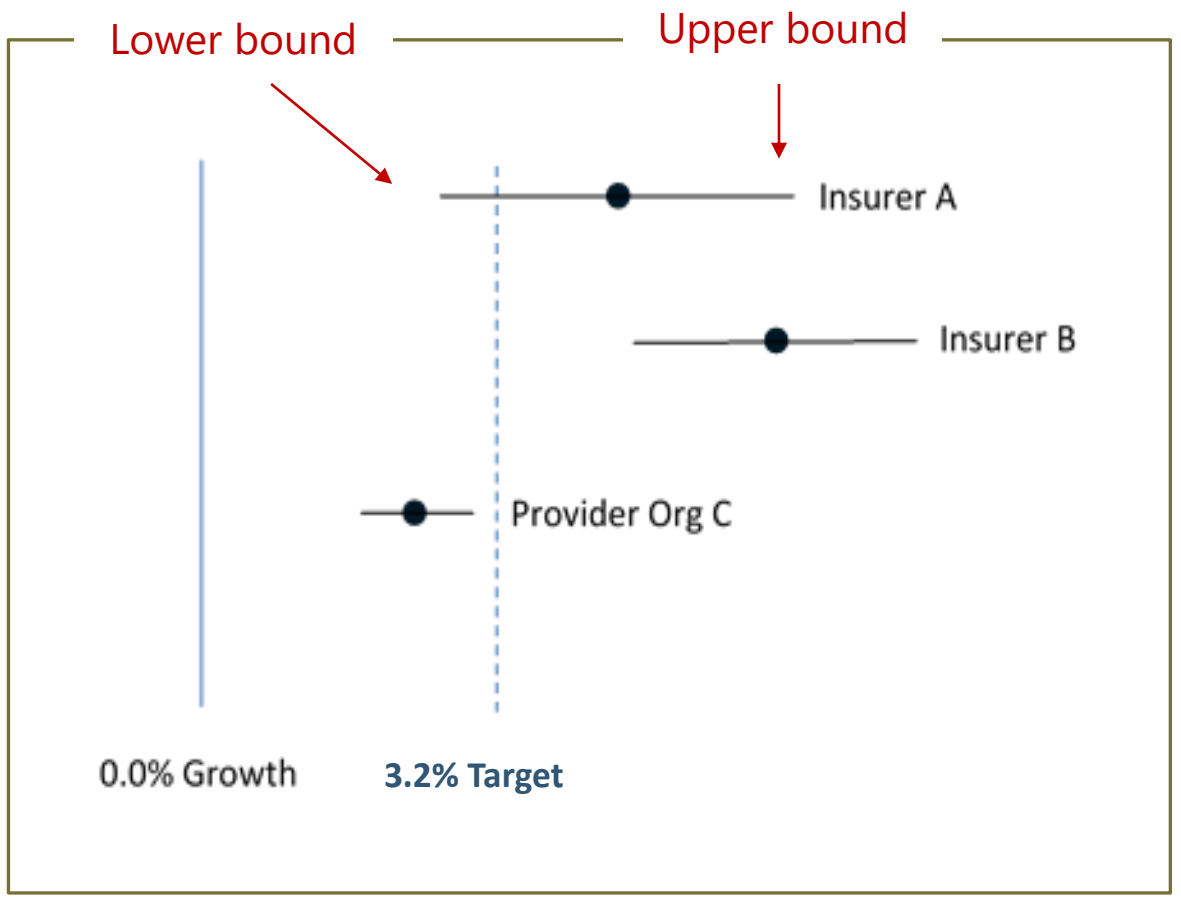
Approach for Members Who Can Be Attributed to More than One ACO/AE During the CY

- Example with a $150,000 truncation point
  - Member in Insurance Category Code 3 was attributed to ACO X for 8 months with $200,000 in claims.
  - Member is then attributed to ACO Y for 4 months with $175,000 in claims.
  - Since the member cost the payer $375,000 in total, the total dollars above the truncation point for the payer would be $225,000.
  - ACO X's spending above the truncation would be $50,000 while ACO's Y spending above the truncation would be $25,000.

3. Development of Confidence Intervals Around Cost Growth

Assessing Performance Against the Target Using Confidence Intervals

- Starting in CY 2020, Target performance will be determined using confidence intervals as follows:
  - Unable to determine performance when upper or lower bound intersects the target (e.g., Insurer A)
  - Target has not been achieved when lower bound is fully over the target (e.g., Insurer B)
  - Target has been achieved when the upper bound is fully below the target (e.g., Provider Org C)



Note: Figure is not to scale

Data Needed to Develop Confidence Intervals

- Payers will need to provide PMPM variance information in the new **Variance – 2019** and **Variance – 2020** tabs:
  - by line of business for the payer overall; and
  - by line of business for each ACO/AE
- Each individual member/attributed life should be included in calculation of variance, regardless of whether the member has any paid claims.
- Variance should be calculated after:
  - Applying adjustments at the member level for Insurance Category Code 4 (Partial Claims, Adjusted)
  - Truncating spending for high-cost outliers at the individual member level

Primary Care Spending Obligation

Overview of Updates

- Revised definition to **align with the Cost Growth Target**, including:
  - Updating the population to include all residents of RI who, at a minimum, have medical benefits and for which the insurer is primary care on a claim.
  - Adopting the same definitions of primary care spending and total medical expenses (but excluding long-term care).
  - Adopting the same fall reporting deadline (i.e., October 1, 2020 and April 1, 2021).

- OHIC also revised the methodology to **include spending only for insurers' fully insured LOB** in aggregate.
  - If insurers cannot separately identify lump-sum non-claims-based payments that are for fully insured vs. self-insured LOBs, they can pro-rate the payment based on market share to identify the portion that is attributable to the fully-insured LOB.

New Non-Claims Methodology

- OHIC is using a new methodology to identify what percentage of non-claims-based spending is allocated to primary care.

- Insurers report non-claims spending by subcategory in a template, which applies a **default percentage to each subcategory to determine primary care vs. non-primary care non-claims-based spending**.
  - For Coastal Medical, the default percentage is 100% because the system of care is largely comprised of primary care providers.
  - For all other ACO/AEs, OHIC developed one set of statewide default percentages using survey responses from the major system of care organizations in RI. This will allow insurers to ***estimate*** their primary care non-claims-based spending and maintain confidentiality of system of care-reported data.
  - After insurers submit data, OHIC will replace the statewide default percentages with the exact percentages reported by the systems of care.

New Reporting Template

- OHIC developed a new template to streamline reporting for the primary care spend obligation, with the following tabs:
  - **Contents**: provides an overview of the reporting template
  - **Mandatory questions**: prompts insurers to answer questions about their data submission to ensure it is in alignment with the revised specifications
  - **HD-PC spending**: requests insurers to identify their organizational ID, reporting period beginning and ending dates and any relevant comments
  - **Primary care spending**: requests insurers to submit primary care and TME data, including:
    - Claims: Professional, primary care
    - Non-claims: HIE payments for CurrentCare
    - Non-claims: PCMH admin. payments
    - Non-claims: Professional, primary care
    - Claims: TME, less long-term care
    - Non-claims: TME, less long-term care

New Reporting Template (Cont'd)

- **Non-claims – ACO_AE**: four tabs that prompt insurers to report non-claims spending for each ACO/AE by subcategory and the composition of primary care providers for each system of care. Includes four tables:
  - ***Table 1***: reporting for organizations within the system of care that largely include primary care providers
  - ***Table 2***: reporting for organizations within the system of care that include primary care providers in part, but not in whole
  - ***Table 3***: reporting for organizations within the system of care that do not include primary care providers
  - ***Table 4***: a summary table of primary care non-claims-based spending, non-primary care non-claims-based spending and total non-claims-based spending
- **Definitions** and **Reference Tables**: includes terms, definitions and additional reference information from the Implementation Manual to aid insurer submission

Alignment Between the Primary Care Spend Obligation and Cost Growth Target

Category	Primary Care Spending Definition	Cost Growth Target Definition	Different or Same
Payers required to report	Commercial payers for fully-insured lives only	All payers for all covered lives (i.e., fully and self-insured commercial, Medicaid, Medicare and dual-eligible members)	
Type of spending	Allowed amounts		Same
Secondary payer payments	Excluded		Same
Non-claims payment timeframe	Incurred		Same
Member residence	RI residents only		Same
Provider residence	All providers, regardless of location		Same

Alignment Between the Primary Care Spend Obligation and Cost Growth Target (Cont'd)

Category	Primary Care Spending Definition	Cost Growth Target Definition	Different or Same
Definition of primary care	Claims-level definition of primary care spending and taxonomy codes to define a primary care provider		Same
Definition of TME	Includes spending for prescription drugs, behavioral health, laboratory and imaging services Excludes spending for dental, vision and long-term care services (beyond those covered by a medical benefit)	Includes spending for prescription drugs, behavioral health, laboratory, imaging and long-term care services Excludes spending for dental and vision services (beyond those covered by a medical benefit)	

Alignment Between the Primary Care Spend Obligation and Cost Growth Target (Cont'd)

Category	Primary Care Spending Definition	Cost Growth Target Definition	Different or Same
Reported claims spending categories	• Professional, Primary Care • TME, less Long-term Care	• Hospital Inpatient • Hospital Outpatient • Professional, Primary Care • Professional, Specialty Care • Professional Other • Retail Pharmacy • Long-term Care • Other	

Alignment Between the Primary Care Spend Obligation and Cost Growth Target (Cont'd)

Category	Primary Care Spending Definition	Cost Growth Target Definition	Different or Same
Reported non-claims spending categories	• HIE Payments for CurrentCare • PCMH Administration Payments • Professional, Primary Care • TME, less Long-term Care	• Prospective Capitated, Global Budget, Case Rate, or Episode-Based Payments • Performance Incentive Payments • Payments to Support Population Health and Practice Infrastructure • Provider Salaries • Recoveries • Other	

CY 2020 Data Submission Process and Timing

File Submission

- Insurers should submit two Excel files with the necessary information required for OHIC to calculate performance against the Target and Primary Care Spend Obligation.
- Insurers must use the Excel file posted on the OHIC website. No data will be accepted if not input into the provided templates.
- Insurers should input their data into the cells and not alter the file in any other way:
  - Cells with blue text will automatically calculate pre-populated formulas.
- Updated specifications and reporting templates for insurers to use are available at: http://www.ohic.ri.gov/ohic-reformandpolicy-costtrends.php

Data Submission Deadline

- Insurers shall report data for:
  - the Cost Growth Target on an annual basis (fall) and
  - the Primary Care Spend Obligation on a semi-annual basis (spring and fall).
- The spring deadline was April 1, 2021 for the preliminary CY 2020 primary care spending data submission.
  - Insurers used the old primary care spending definition for this submission.
- The fall deadline for the CY 2020 cost growth and primary care spending data submissions was originally August 1, 2021.
  - Due to need to implement important methodological changes the deadline is now **October 1, 2021**.

Reporting Timeframe

Payer Initial Primary Care Data Submission

Payers submit preliminary primary care spending for CY 2020.

Performance Announced

OHIC will report on performance relative to the Obligation and Target in late 2021 or early 2020.

Future Target

The State will re-evaluate the Target methodology in 2022 for possible revision for the 2023 performance year.

Payer Cost Growth and Final Primary Care Data Submission

Payers submit CY 2019 and 2020 cost growth and final CY 2020 primary care spending data (will be submitted on August 1 in 2022 onwards).

Annual Process

In 2022, payers will submit CY 2021 data and OHIC will report performance.

Questions?

Resources

- Health Care Cost Growth Target Implementation Manual: http://www.ohic.ri.gov/documents/2021/August/16/RI%20Implementation%20Manual_CY%202019-CY%202020_FINAL.pdf
- Cost Growth Target Performance Submission Template: http://www.ohic.ri.gov/documents/2021/August/16/Attachment%201%20Rhode%20Island%20Cost%20Growth%20Target%20Performance%20Submission%20Template%202021%208-11.xlsx
- Variance Calculation Example: http://www.ohic.ri.gov/documents/2021/August/16/RI%20Variance%20Example%208.10.21.xlsx

Contact Information

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