Rhode Island Health Care Cost Trends Project
Steering Committee Meeting Minutes
Virtual Meeting through Zoom
May 17, 2021
9:30–11:00 am

Steering Committee Attendees:
Tim Babineau, Lifespan
Al Charbonneau, Rhode Island Business Group on Health
Tony Clapsis, CVS Health
Michael DiBiase, Rhode Island Public Expenditure Council
Stephanie De Abreu, UnitedHealthcare of New England
Jim Fanale, Care New England
Diana Franchitto, Hope Health
Peter Hollmann, Rhode Island Medical Society
Al Kurose, Co-chair, Coastal Medicine
Michele Lederberg, Co-chair, Blue Cross Blue Shield of Rhode Island
Jim Loring, Amica Mutual Insurance Company
Peter Marino, Neighborhood Health Plan of Rhode Island
Betty Rambur, University of Rhode Island College of Nursing
Beth Roberts, Tufts Health Plan/Harvard Pilgrim Health Care
Sam Salganik, Rhode Island Parent Information Network
Ben Shaffer, Rhode Island EOHHS
Neil Steinberg, Rhode Island Foundation
Patrick Tigue, Co-chair, Office of the Health Insurance Commissioner
Teresa Paiva Weed, Hospital Association of Rhode Island
Larry Warner, United Way of Rhode Island
Larry Wilson, The Wilson Organization

Unable to Attend:
Nicole Alexander Scott, Rhode Island Department of Health

1. **Welcome**
   - Michele Lederberg welcomed Steering Committee members to the May meeting and notified attendees that the meeting was being recorded.

2. **Approve meeting minutes**
   - Patrick Tigue noted that there was a small change to the meeting minutes which Steering Committee members received in advance of the May meeting. The change was to reflect that Jim Fanale had indicated his interest in participating on the VBP Subcommittee. This edit has been made and will be reflected in the minutes that are posted online.

- The Steering Committee voted in favor of approving the April meeting minutes with no opposition or abstentions.

3. Implications of 2019 cost trends results for future action

- Michael Bailit asked Steering Committee members to consider how they think the Cost Trends Project should respond to the 2019 performance results showing that the state exceeded the cost growth target of 3.2%. He noted that recent and current actions the Steering Committee has endorsed included: 1) pharmacy analyses and recommendations supporting price legislation; 2) creation of a VBP Subcommittee; and 3) further analyses of hospital outpatient spending and "other professional" spending (which was presented to members during the May meeting.)
    - Jim Loring asked if there was benchmark data that the Cost Trends Project could compare some of the cost categories against to get a better sense of where Rhode Island stands. Jim asked if Massachusetts has data against which Rhode Island could compare.
    - Al Charbonneau replied to Jim, sharing that there are National Association of Insurance Commissioners (NAIC) data that are available that would give a perspective on costs, Medicare cost reports, research conducted by RAND. Al said that all of those data are available free of charge. Al said something needs to be done in Rhode Island to address hospital costs and growth and said it would be informative to look at other data.
    - Michael Bailit said there are some comparisons that could be made with other states and doing so with Massachusetts was relatively easier because of similar methodologies. Michael said Rhode Island could also compare with Connecticut. He noted that other states are seeing similar trends with hospital outpatient spending, but that "other professional" spending growth rates were not surfacing as a significant cost driver in other states as in Rhode Island.
    - Peter Hollmann said the consequences are that we needed to work on performance and implement improvements.
    - Patrick Tigue responded to Michael's question about how to respond to the cost growth target performance results by saying the Cost Trends Project needed to double down on the work. He said it speaks to the importance of measuring performance and holding entities and the Steering Committee collectively accountable. Patrick also said that one thing that came out of the public meeting in May was the importance of focusing on the drivers of cost growth and on the underlying cost structure. Patrick said the Cost Trends Project will need to have a dual focus on the costs and cost drivers.
- Sam Salganik noted the lack of Implementation Committee discussion around the proposed hospital merger in the context of hospital outpatient costs as a growth driver. Sam acknowledged that the conversation might be difficult to have and did not express an opinion on how the merger might impact costs but said it would represent a potential sizeable shift in the market.
    - Michael Bailit asked the Steering Committee about the implications the proposed merger would have for the Cost Trends Project.
    - Sam Salganik replied that he did not know but there might be some public discussion and debate around costs. He said there were involved hospital

representatives among the Committee members. He noted he wasn't sure if it was an appropriate forum to talk about the potential merger but said it will likely impact the work one way or the other and that it is something that would be worth discussion. He suggested that the co-chairs consider this.
    - Tim Babineau said it was a legitimate question that he and Jim Fanale have discussed. He indicated that there will be several public forums through which Tim and Jim will be presenting the case for the merger. He said those have not yet started and reported that the regulatory filings were received in the last few weeks. He said that he and Jim have reached out to groups to begin conversations and that Neil Steinberg has agreed to host public forums. Tim said the forums will focus on cost, quality, access and equity. He said he wasn't sure of the role of the Cost Trends Steering Committee but invited input formally or informally and said he would be happy to talk with the group at a later date when public discussion of the topic was underway.
    - Michele Lederberg said that the Steering Committee meeting is a good place to have a conversation about the implications of these types of mergers to talk about the cost implications since cost and cost growth over time are the primary focus areas of this work.
    - Patrick Tigue agreed with Michele's comments on the merger noting that it is a market variable that is foundational to the work the Steering Committee is doing. Patrick suggested that the co-chairs think about how to structure future discussions on the topic.
- Larry Wilson expressed concern about demography and the groups that are being most hurt by increasing health care costs and growth. He reiterated the need to put a human face on the data and said the video at the May public meeting did that. He asked the Steering Committee to consider "what groups of people get added then to the already existing group that is heavily impacted by exceeding the target?" He said the Steering Committee has an obligation early on – if the target is not met in the future – to be mindful of how those will continue to be impacted in an outsized way and what the Cost Trends Project might do to help.
    - Michael Bailit said that working people with modest-to-low income are the most likely to be hurt and said the 2018 compact was a commitment among the members at the table to work together to meet the target.
    - Al Kurose said the Steering Committee needs to keep coming back to those questions and acknowledged that they are hard to answer. Regarding value-based payment, Al noted that it had been Coastal's experience that getting the payment models right may not be enough or sufficient, but it was foundational.
- Neil Steinberg asked if legislators and the Governor's Office were aware of the state missing the cost growth target and what their thoughts were.
    - Patrick Tigue said he had briefed the Governor and key advisors on the performance relative to the cost growth target, the drivers of growth, and the steps that have been taken to report the performance results publicly. He said he would continue to engage the Governor's Office in the work and invited other members to do the same. He also said leaders are deliberating on the unsupported price increase legislation.

    - Ben Schaffer said discussions of cost growth target performance also surfaces when considering the impact on the Medicaid budget and how exceeding the target impacts Medicaid. He said it also comes up in discussions of accountable care and value-based payment.
- Peter Hollman asked the question about how performance should be assessed in a "highly atypical year."

4. Methodological challenges with reporting 2018-19 performance at the insurer and ACO/AE levels

- Michael Bailit discussed learnings from the first-year performance results and noted that high-cost outliers and changes in risk scores had a significant impact on insurer and ACO/AE performance. He explained that high-cost outlier spending is associated with random events and that risk score changes are to ensure providers caring for increased numbers of individuals with high care needs are not penalized or doing so. He noted that risk score changes may reflect changes in a patient population but also in provider diagnosis coding practices. Michael said during the June Steering Committee meeting he would present recommendations to change the methodology to mitigate the impact of those two factors.
- Teresa Paiva Weed asked about the status of the data with respect to including self-insured.
- Michael Bailit said the self-insured population is included when assessing performance relative to the target. (Michael noted that the APCD data does not include much self-insured data, however.)
- Sam Salganik asked if the methodology to measure ACO / AE and payer performance included risk adjustment.
- Michael Bailit responded to Sam, explaining that the current methodology included risk adjustment, adding that it had an inconsistent impact, with his hypothesis that differences in change over time reflected differences in coding practices rather than differences in patient population profiles.
- Sam Salganik asked if high-cost outlier spending would typically be excluded.
- Michael Bailit said high-cost outlier spending is actual spending, but said the question is whether that spending should be included when assessing ACO / AE performance relative to the target.
- Lisa Holland (UnitedHealthcare) asked if the analysis factored in stop loss for those high-cost payments when doing the methodology for risk categories.
- Michael Bailit said the current methodology did not make any adjustments for high-cost outlier spending.
- Patrick Tigue said an important policy goal is to be sure the data aligns with performance to be able to draw the right lessons from reporting and assessment. He said if an entity is high performing, it is important to understand lessons and best practices, which can only be done if the results are not resulting from random variation. He said it is a data integrity issue with practical impact for the cost trends work.
- Al Kurose said that there should be a timeline for reporting absolute cost information and then cost trends.
- Sam Salganik asked the following question in the chat box: "If these impacts make our data hard to "trust" (for lack of a better word), might that impact that our

ACO/AEs are not large enough?" Michael Bailit replied that he did not think this was necessarily the case.

5. **Cost driver analysis: 2019 hospital outpatient and other professional spending**
    - Ira Wilson and Megan Cole (Brown) presented analysis and initial findings of a deeper look into hospital outpatient and "other professional" spending, as those areas of spending were shown to be primary contributors of cost growth in 2019.
    - Pano Yeracaris (CTC-RI) noted in the chat box that he did not see pediatrics in the primary care bucket and asked if it was an oversight.
    - Michael Bailit asked if members had any comments or reflection on the patterns observed and why there was an increase utilization in these services.
    - Neil Steinberg said that he was under the impression that more care is coming from nurse practitioners and physician assistants and that was a good thing because it means care is "moving down the cost chain." He wondered if this explained the volume increase and if there was a parallel decrease in volume of physician services.
        - Michael Bailit said that a decrease in physician service spending was not observed. He also pointed out that the growth levels, particularly for counselors, were significant.
        - Betty Rambur said she expected the results to reflect the greater opening of care from nurse practitioners and physician assistants and the present demand for counselors, particularly among students and young adults. She said she thought there would be more volume there and hoped that it represented needed services.
        - Sam Salganik said that individuals seeing nurse practitioners or physician assistants might not be able to get an appointment with a physician, particularly a behavioral health clinician. He wondered if it was possible to have both an additive impact and be less expensive than adding capacity at the physician level. He said it was hard to know without know the subspecialty. He wondered if it might be a less expensive way to expand access.
        - Tim Babineau reported that Lifespan is hiring more "physician extenders" as a deliberate part of its workforce strategy. He reported difficulty recruiting physicians in Rhode Island due to low reimbursement. He said he was not surprised by the increased utilization of nurse practitioners and physician assistants because it reflected a very deliberate workforce development strategy.
    - Al Charbonneau said Milliman rates Rhode Island as a "loosely managed" care state primarily because of the predominance of PPOs in the state. He asked how much of the utilization is a function of it being primarily a PPO state.
        - Peter Hollmann said Rhode Island has been a PPO state for decades and that there needed to be consideration for how nurse practitioners and physician assistants are classified. He said some of the changes seem like they could be shifts in coding and payment. He also suggested looking to see if the big jumps had to do with a change in benefit categories.
        - Beth Roberts said she didn't think the results had to do with PPOs. She said this is not the typical jump that would be observed and cautioned against looking at this in isolation because it might be a good pattern. She said people might be accessing care at the nurse practitioner and physician assistant level and avoiding higher-cost services thereby offsetting higher-cost spending.

    - Michael Bailit noted that the analysis did not show spending offsets in other categories.
    - Al Kurose said the workforce development has been strategic and deliberate but there has not been evidence of mitigating growth in other categories.
- Betty Rambur said from a patient point-of-view, if a patient sees an independent provider, that patient is charged but if the independent provider goes into a hospital, the patient is also charged a facility fee.
    - Ira Wilson said facility fees can only be charged if the entity is a facility. He said there is national debate about the practice of hospitals buying outpatient practices and then charging facility fees as if the outpatient practice were a hospital facility.
- Tim Babineau noted that the schedule of drugs in the analysis were all chemotherapy agents and that those are expensive drugs that are delivered in an outpatient infusion center, typically administered by hospitals.
    - Michael Bailit asked if that would explain the observed utilization growth.
    - Tim Babineau said he wasn't sure it would explain a 40% increase but also said the cancer center had expanded and patient volume had increased.
    - Peter Hollmann said it was interesting to see the J codes classified as "other professional", noting that Medicare reports classify them as hospital outpatient codes. Peter said it could be more available and advanced cancer treatments and that more of that care is happening in Rhode Island rather than out-of-state. He also said it is the case that hospitals cannot acquire a practice and make it a hospital outpatient facility, at least under Medicare rules.
    - Sam Salganik observed that more and more hospitals (nationally) advertise and invest in cancer care capacity.
    - Beth Roberts agreed with this observation and said it would be important to look at the split of utilization and cost for the other categories of cost, particularly medical drugs.
    - Sam Salganik said he would like to see price vs. utilization breakdowns in future analyses.
- Jim Loring noted that not all hospital facility ambulatory centers are provider-based services and that there are restrictions in what can be done. He said it was important to note that when Medicaid reimbursement does not cover costs, a facility fee helps to pay for that. He said it was important to look at the entire picture of reimbursement and noted that the concept that practices are acquired and billed as facilities "is not something we can do."

6. VBP Subcommittee

- Cory King identified Steering Committee members who expressed an interest in participating on the VBP Subcommittee (or identified a designee).
- Cory King indicated that the VBP Subcommittee would begin meeting in July 2021.
- Teresa Paiva Weed indicated that it might be valuable to invite someone from Providence College, Rhode Island College, or the University of Rhode Island.

7. **Informational updates**
    - Patrick Tigue indicated that there were no new updates to the pharmacy legislation or the sustainability assessment. He said he hoped to have more to report during the June Steering Committee meeting.

8. **Public comment**
    - There were no comments from the public.

9. **Next steps and wrap-up**
    - Al Kurose said the next Steering Committee meeting will take place on June 28th from 9:00-10:30 am.