Rhode Island Health Care Cost Trends Project

Steering Committee Meeting Summary
State House Room 313, 82 Smith Street, Providence
August 29, 2018
9:00am – 12:00pm

Steering Committee Attendees:
Tim Babineau, Lifespan
Al Charbonneau, RI Business Group on Health
Adriana Dawson, Bank Newport
Jim Fanale, Care New England
Stephen Farrell, UnitedHealthcare of New England
Marie Ganim, Co-chair, Office of the Health Insurance Commissioner
Peter Hollmann, RI Medical Society
Kim Keck, Co-chair, Blue Cross Blue Shield of Rhode Island
Chris Koller, Milbank Memorial Fund
Al Kurose, Co-chair, Coastal Medicine
Teresa Paiva Weed, Hospital Association of Rhode Island
Betty Rambur, University of RI College of Nursing
Sam Salganik, Rhode Island Parent Information Network
John Simmons, RI Public Expenditure Council
Neil Steinberg, Rhode Island Foundation
Larry Wilson, The Wilson Organization

Steering Committee Members Unable to Attend:
David Cutler, Harvard University

Steering Committee Staff Attendees:
Kim Paull, Executive Office of Health and Human Services
Cory King, Office of the Health Insurance Commissioner
Anya Rader Wallack, Brown University
Amal Trivedi, Brown University
Ira Wilson, Brown University
Megan Cole, Boston University
Michael Bailit, Bailit Health
Justine Zayhowski, Bailit Health

Cost Trends Project Overview

- Co-chairs Kim Keck and Al Kurose welcomed the Steering Committee to its initial meeting.
- Marie Ganim introduced the project and thanked the Peterson Center on Healthcare for providing support through 6/30/19. She reviewed the project's vision statement: "To provide Rhode Island citizens with high-quality, affordable health care through greater transparency of health care performance and increased accountability by key stakeholders." She also presented the project's goals and three work streams (cost growth targets, data analysis, and data use strategy).
- Marie Ganim reviewed the Steering Committee's charge and expectations of members.
    - Marie Ganim noted that if anyone has recommendations or issues with the materials please notify the co-chairs, and the project team will work to address your feedback.
- Michael Bailit described the work streams, noting that they are happening in parallel but also impact each other.
- The Steering Committee asked if part of the Peterson Center grant award could be shared with the Steering Committee. Ira Wilson replied that Brown could share the document.
- **Action Step:**
    - The Steering Committee will be provided with a copy of the Peterson grant award.

Cost Trends Work: Historical Context

- Michael Bailit reviewed 2016 efforts to develop a cost growth target.

Data Analysis Goals and Plan:

- Megan Cole presented the draft data analysis plan. Ira Wilson and Megan Cole noted that the development of the data analysis is an iterative process and that they are hoping for the input of the Steering Committee throughout the process. They plan on providing updates at future Steering Committee meetings and soliciting feedback.
- **Exclusions** include smaller plans, non-Rhode Island residents receiving care in Rhode Island, Rhode Island residents receiving most of their primary care outside of Rhode Island, enrollees with less than 12 months of continuous coverage, health plans with a minority of covered lives, and lives not reported in the APCD (some self-insured, VA, TRICARE, uninsured).
    - Neil Steinberg and others asked how many covered lives are excluded.
    - Teresa Paiva Weed noted that there are a large number of people who do not declare residency in RI.
    - Marie Ganim clarified that many self-insured have data in the APCD.
    - Michael Bailit noted a larger percentage of self-insured lives are reportedly contained in the RI APCD than in other state APCDs.
    - Tim Babineau noted that the uninsured are a very expensive population and while the ACPD does not have data on this group, they are the most expensive patients.

        - Sam Salganik asked why the data analysis team excluded residents primarily receiving care in MA.
            - Megan Cole said that from an accountability standpoint, if a resident is receiving care in MA, then RI providers cannot act on their costs.
                - Kim Keck and Tim Babineau noted there is a big impact from specialty care being delivered in MA. The higher MA costs are reflected in RI premiums.
                - Kim Keck noted the differential in cost of care between RI and MA is bigger than between NJ and NY.
            - Michael Bailit flagged that the populations and costs captured in the proposed data analysis and in the cost growth targets may not completely align.
            - Megan Cole said that she is planning to do a sensitivity analysis to see what the impact is of various exclusions.
                - Peter Hollmann said that as long as there is not a dramatic skew based on exclusions, Megan Cole's data should be reasonable.
- **Patient Attribution** will be done by payer and provider. Payer attribution will be performed by looking at enrollment start and end dates. Provider attribution will be done based on utilization.
    - Sam Salganik noted that the Medicaid ACOs are attributing based on the PCP. Sam Salganik is interested in leveraging the data on an all-payer basis and asked if it would be difficult to attribute based on PCP for at least a subset of the population.
    - Megan Cole said there is not an APCD data field on PCP assignment and that external data would be needed to link to PCPs. Megan Cole noted for the majority of cases the utilization approach should link patient to the same PCPs if their PCP is the provider from whom they actually receive care.
- **Total cost of care** is measured as total expenditures per person per month, with monthly member expenditures aggregated across each calendar year, weighted by member months.
    - Megan Cole said that expenditures are inflated based on a price adjustment factor based on 2018 dollars and truncated at $125,000 per member.
        - Jim Fanale noted that there are a lot of high cost members this year. He agrees with the methodology outlined, but also thinks that the data analysis team should look at the costs of those over $125,000 and see what are driving their costs. Kim Keck agreed.
        - Neil Steinberg asked about administrative expenses, noting that these costs can be considerable.
        - Kim Keck noted there is also a large amount of money in the category of non-claims-based payments. Stephen Farrell and Al Kurose agreed.
            - Al Kurose noted that OHIC has been tracking non-claims-based payments as a percentage of the total.

        - Cory King noted that non-claims-based payments are 2-4% of the total costs of care and admin is about 10%. Al Kurose noted it is important to remember these figures as they put the scope of these exclusions in perspective.
    - Megan Cole noted capitation and bundled payments are in the APCD.
    - Al Charbonneau noted that large hospital overhead costs cannot be ignored if the data analysis is to understand value. There are also mandated benefits and other costs that should be considered.
- **Adjustment for Patient Characteristics and Health Status** will be made. Health status will be adjusted by employing the 3M Clinical Risk Groups (CRGs). The 3M CRGs are claims-based adjustments used for all payers and ages. There are 180 different clinical groups. This adjustment was used by VT when analyzing its APCD.
    - Sam Salganik thanked Megan Cole for including the zip code index and the area deprivation index and asked for information about the difference.
        - Megan Cole said that zip code is an income proxy and that the area deprivation index includes other factors. She noted that the area deprivation index was developed by UMass and has been used by Massachusetts.
    - Larry Wilson asked to what extent are the data impacted negatively by a lack of data on race and ethnicity and what this does to the findings.
        - Megan Cole noted that other states have not used race/ethnicity due to missing data.
        - Michael Bailit said since we do not have the data we do not know how race/ethnicity will influence the findings.
        - Larry Wilson is concerned about accuracy of race and ethnicity data. He is also concerned about the uninsured and what impact that exclusion has on the accuracy of the analysis.
        - Megan Cole said the lack of this information limits the ability of the analysis to determine whether ethnic and racial minority costs and cost drivers are different.
    - Larry Wilson asked whether addition exclusions are likely to be added in the future.
        - Megan Cole noted there are no other exclusions that she thinks that we would need to exclude, but this could change during the course of the analysis.
- **Aim 1: Analytic Approach – Cost Trends.** The data analysis will look at changes year to year from 2014-2017.
- **Aim 2: Analytic Approach – Cost Drivers.** All analyses will be stratified by payer type, health plan, and provider group. The data team will prioritize 2-4 drivers and proposes first looking at drivers by categories of medical spending.
    - Kim Keck asked if there was an ability to categorize by condition (e.g., COPD). Megan Cole noted that the analysis could look at conditions as part of Aim 3.

- Peter Hollmann noted that drug costs are significant and can end up being hidden in outpatient costs.
- Betty Rambur noted that there are data challenges with behavioral health data.
    - Jim Fanale responded there may be clinical data restrictions, but not restrictions on cost data.
- A member of the Steering Committee asked if the subsets will be all risk-adjusted. Megan Cole noted they will be.
    - Peter Hollmann noted that usually the risk-adjustment models are not based on sub-types of expenditures, but based on total costs of care. Michael Bailit agreed.
- Teresa Paiva Weed noted that ER services are cost drivers and asked if they could be separated out. Megan Cole responded that the data analysis can separate out these costs.
- Al Kurose asked if anyone has looked at hospice costs. Megan Cole said the data team can look into this.
- Teresa Paiva Weed asked if there was a distinction for services done at freestanding facilities vs. hospitals. Megan Cole noted it depends on how the service is billed.
- Kim Keck asked about diagnostic testing. Megan Cole noted this falls into "other medical."
    - Teresa Paiva Weed noted that this is a cost driver nationally.
    - John Simmons asked if the data analysis could separate out some of the "other" category.
- Ira Wilson flagged that the APCD is a rich dataset, but reminded the group that Brown is not funded to do a comprehensive evaluation. The Steering Committee and Brown will need to discuss how to prioritize services that are both interesting and important to examine. He mentioned that the group must think broadly but also focus its efforts.
    - Neil Steinberg asked if the Steering Committee will have enough information to focus on interesting items with a large impact on costs. Ira Wilson confirmed that it will.
    - Al Kurose asked if the Steering Committee and Brown want to look at the categories holding the most dollars or the areas in which the health care community can manage and have the most impact.
        - Ira Wilson said he thinks the community wants to hear about things that vary and are actionable. The biggest bucket is inpatient, but the group may want to focus on a different topic area instead.
        - Kim Keck noted that the group may want to focus on a policy area where we do not have existing research or policy. She said that RI has looked at PCPs and their impact and that there is unit cost regulation for hospitals. She noted that there has been little work done understanding the impact of specialists.

        - Jim Fanale noted the rise in pharmacy and outpatient specialist surgery use in RI is extraordinary.
    - **Action Steps:**
        - Michael Bailit noted if there are different recommendations for categories of medical spending, Steering Committee members should please share them with Megan Cole after the meeting.
        - Ira Wilson noted that the Steering Committee should let Megan Cole and Ira Wilson know if they are interested in looking at annual expenditures by different subgroups.
- **Aim 3: Analytic Approach – Volume and Price.**
    - Al Kurose noted that there is regulation of hospitals and ACO budgets in Rhode Island. There is no regulatory construct for specialty. He asked if there is a way the data analysis can looking at existing benchmarks for utilization and create metrics that might end up in regulation at a later period in time.
    - Megan Cole said the data analysis team plans to look at episodes of care, leveraging work done by Altarum. This data can be used to look at a subset of disease categories or services.
        - Kim Keck asked if the Altarum work looked at benchmarks to other states. Michael Bailit noted the analysis was focused on episodes within RI.
    - Betty Rambur asked about low-value, high-cost care.
    - Ira Wilson said that he would like the group to think about this analysis as the beginning of a process that needs funding, political commitment, and social commitment to be able to really look at value. Ira Wilson agreed with Tim Babineau that the analysis should look at cost in the context of outcomes.

Cost Growth Targets

- Michael Bailit defined cost growth targets as a per annum rate of growth target within a state to the extent that it is practical to measure.
- **RI Context:** RI had the 10th highest per capita expenditures per state, as of 2014. The OHIC-approved 2018 premium increases for the small and large group markets were 6-8 and 8-10% vs. 3.7% Q1 2018 wage growth. In the commercial market, health care costs continue to rise, outpacing wages and inflation.
    - Michael Bailit shared RI Medicaid data for the three most recent years (post-ACA). Medicaid expenditures increased 3.1% yet the population grew 6.1%. He noted that the expansion population has low risk scores. Per capita growth for Medicaid has decreased 2.7% in part due to populations and also due to State initiatives.
- **Massachusetts Cost Growth Target:** MA is the only state that has operationalized a true health care cost growth target. The target was established through statute (Ch. 224) which created the Health Policy Commission (HPC), which was charged with establishing annual cost growth targets and monitoring the state's progress through annual hearings.

- The rationale for establishing the cost growth target was that the huge growth in health care costs were causing reductions in spending for social services.
- By April 15 of each year, the HPC must set a target growth rate for the next calendar year. The benchmark is tied to the expected long-term growth in the state's economy using the potential gross state product (PGSP). The Secretary of Administration and Finance and House Ways and Means Committee chairs must agree on the target by January 15. Michael noted that MA currently has a multi-year target and is not changing the target on an annual basis.
- In 2018 the target changed from PGSP (3.6%) to PGSP -0.5% (3.1%). All payers and drug costs are included. Michael Bailit noted that while the state targets are supposed to be for overall spending, the commercial market has been using these benchmarks in commercial negotiations.
    - Al Charbonneau asked if anyone has looked at cost growth targets based on what needs to be done to make health care affordable. Michael said that MA and DE did not look at its targets this way. If RI wanted to look at targets this way, it could.
- In 2022, the MA legislation dictates that the default target should be set at PGSP and then after that the HPC can set the target without restriction.
- Michael Bailit noted that there are no real ramifications for exceeding the target. If the HPC elected to do so, it could require a performance improvement plan and a fine of $500,000 if a provider failed to submit a plan. However, since the HPC has never required a plan, there have not been any fines to date. If the HPC does not think that the benchmark is working, it may submit a recommendation for proposed legislation to the legislature.
- MA measures total health care expenditures (THCE), which include all medical expenses, patient cost sharing (allowed claims), and the net cost of private health insurance (insurer administrative expenses and contribution to reserves/profit).
    - Betty Rambur asked if Part D was included. Michael Bailit said he does not think that Massachusetts can get Part D data, but the measure includes pharmacy spending by other payers.
- Michael Bailit said that the state's Center for Health Information and Analysis identified pharmacy and hospital outpatient as major cost drivers during a recent time period.
- Michael Bailit noted the target has been generally seen as effective. David Cutler was reported to have said that with expected utilization increase of about 2%, payers and providers are generally agreeing on price increases of about 1.5%. HPC looks at performance compared to the target in the context of cost drivers.
- Al Kurose asked if the statute provided for CHIA and the funding for CHIA. Michael Bailit confirmed that it did.
    - Al Kurose noted that MA put its governance and funding for structure step in step.

        - Criticisms of the MA system are that it is based on state gross domestic product (which is not an indicator of affordability), it includes federal spending which MA cannot control, growth caps have the potential to lock in historical disparities in payment, and new technologies, epidemics, and other unforeseen circumstances are beyond the control of providers and insurers.
            - Michael Bailit noted that in MA it was never the intent that every payer and provider would meet the target every year. He also noted that the HPC does consider uncontrollable health care costs (e.g., introduction of Sovaldi) when assessing performance against the target.
- **Delaware Health Care Cost Growth Targets:** Delaware is establishing a five-year cost growth target in conjunction with quality targets. This cost growth target is being created through executive order next month. The state formed an advisory group (also by executive order) to advise the state on establishing the target. The group chose to use the same measure of economic growth as Massachusetts (PGSP) and also did not recommend a penalty.
    - Michael Bailit noted that on Monday, August 27, the Delaware Secretary of Health and Social Services presented recommendations for the cost growth target to the governor.
        - **Action Step:** Michael Bailit will share the DE report with the Steering Committee.
    - Al Kurose thinks that the MA system has longevity, as there is a governance structure that can weigh in on what to do if the state is out of compliance with the target. He asked how DE would monitor their targets.
        - Michael Bailit said the governor is establishing a target for the next five-years but thereafter, the DE Health Care Commission will establish the target and own all cost target work.
    - Teresa Paiva Weed mentioned the importance of ensuring that once the targets are established RI needs to make sure that the institutions making the investments do not go away, adding that an executive order, for example, can be rescinded.
- **Maryland.** Maryland has been regulating all-payer hospital rates under a federal waiver since the 1970s. Regulating rates led to an increase in service volume, so in 2014 the state moved to a hospital global budget model. The state does have the infrastructure to set rates. It used projected state economic growth as measured by GSP to limit hospital growth to 3.58%
    - Michael Bailit noted that MA, DE, and MD each have different approaches to setting targets. MA used statute, DE is using an executive order, and MD used a waiver agreement with CMS.
    - There are big consequences if MD does not meet its goals. If it does not meet its target during the five-year performance period, the state will have to transition back to the national Medicare payment system, which they do not want to do.
    - MD has annually been way below the target since 2014. Studies have provided a more mixed assessment of how MD has performed.

- **Vermont.** 2017 Vermont entered into an all-payer ACO model with Medicare, Medicaid (under an 1115 waiver), commercial payers and the state's sole ACO. The model anticipates providing care to 70% of state residents and 90% of Medicare beneficiaries by 2022.
    - The agreement includes a per capita growth rate of 3.5% and requires savings for Medicare. The growth rate is modeled off of the Medicare Next Generation ACO model and the services in the target exclude pharmacy.
    - Vermont built in flexibility for unanticipated factors. If spending is over 4.3% the state must submit a corrective action plan.

Total Health Care Costs

- Michael Bailit said that a cost growth benchmark is predicated on understanding what are the total costs of health care to be able to compare year-over-year change to the benchmark. As such, the Steering Committee needs to answer the following questions:
    - Whose health care costs are being measured?
    - Exactly what costs should be measured?
    - Where do the data come from?
- Michael Bailit asked the group which populations should be included in measuring total costs of care and if there are any categories the Steering Committee should consider outside of: Medicare, Medicaid, Commercial, Veterans Health Administration, the Federal Employee Health Benefit program (FEHB), TRICARE (the health insurance program for members of the military and their dependents), and the state correctional health system.
    - Sam Salganik said the uninsured population should also be included. Michael Bailit noted that while the expenses are significant for providers, this care is also partially subsidized through commercial payers and other means.
    - Michael Bailit mentioned that there are data access issues that warrant consideration. MA and DE do not use their APCDs to calculate performance against the cost growth target. MA believed that it would be more effective to have carriers, Medicaid, and Medicare provide per capita information as it is more reliable and the APCD would require months of data cleaning. DE has a nascent APCD.
        - Kim Keck noted that these kinds of data requests add to BCBSRI's administrative expenses.
        - Michael Bailit noted that VT is doing its calculations from the APCD.
        - Stephen Farrell noted that the MA cost growth target data submission is a big, costly lift.

Next Meetings and Wrap-Up

- **Next Meeting:**
    - The 9/17 Steering Committee will begin by continuing discussion of which populations should be included in "total health care costs." The majority of

the meeting will be continued discussion on the development of health care cost growth target methodology.

- The meeting will take place at 9:00am at 301 Metro Center Boulevard, Room 203 in Warwick.