Rhode Island Health Care Cost Trends Steering Committee

THIRD MEETING, SEPTEMBER 24, 2018

Agenda

1.	Welcome and Follow-up from Previous Meeting	9:00 am – 9:30 am
2.	Cost Growth Targets: Target Performance Assessment	9:30 am – 10:45 am
3.	Break	10:45 am – 11:00 am
4.	Cost Growth Targets: Authority and Governance	11:00 am – 11:30 am
5.	Data Analysis: Patient Attribution	11:30 am – 11:45 am
6.	Public Comment	11:45 am – 11:55 am
7.	Next Steps and Wrap-Up	11:55 am - Noon

Reminder: Why Are We Here?

Last week the co-chairs tasked us with considering the purpose of the target when making decisions, and, in particular, to what we are tying the target.

As a reminder, in the application to the Peterson Center on Healthcare for this grant, the State said its vision was to provide Rhode Island citizens with high-quality, affordable health care. The application further states that the purpose of this project is to reduce growth in health care costs and state health care spending.

Please keep this in mind as we continue our conversation…

Follow-up Items From September 17th

1. During our September 17th meeting, we discussed which populations to include in the total cost growth spending calculations.
   - Questions arose around the value of spending from the VHA and correctional health system compared to total spending; and whether those two populations were growing.

2. We'll continue our discussion of the most appropriate target methodology and propose some straw models for consideration.

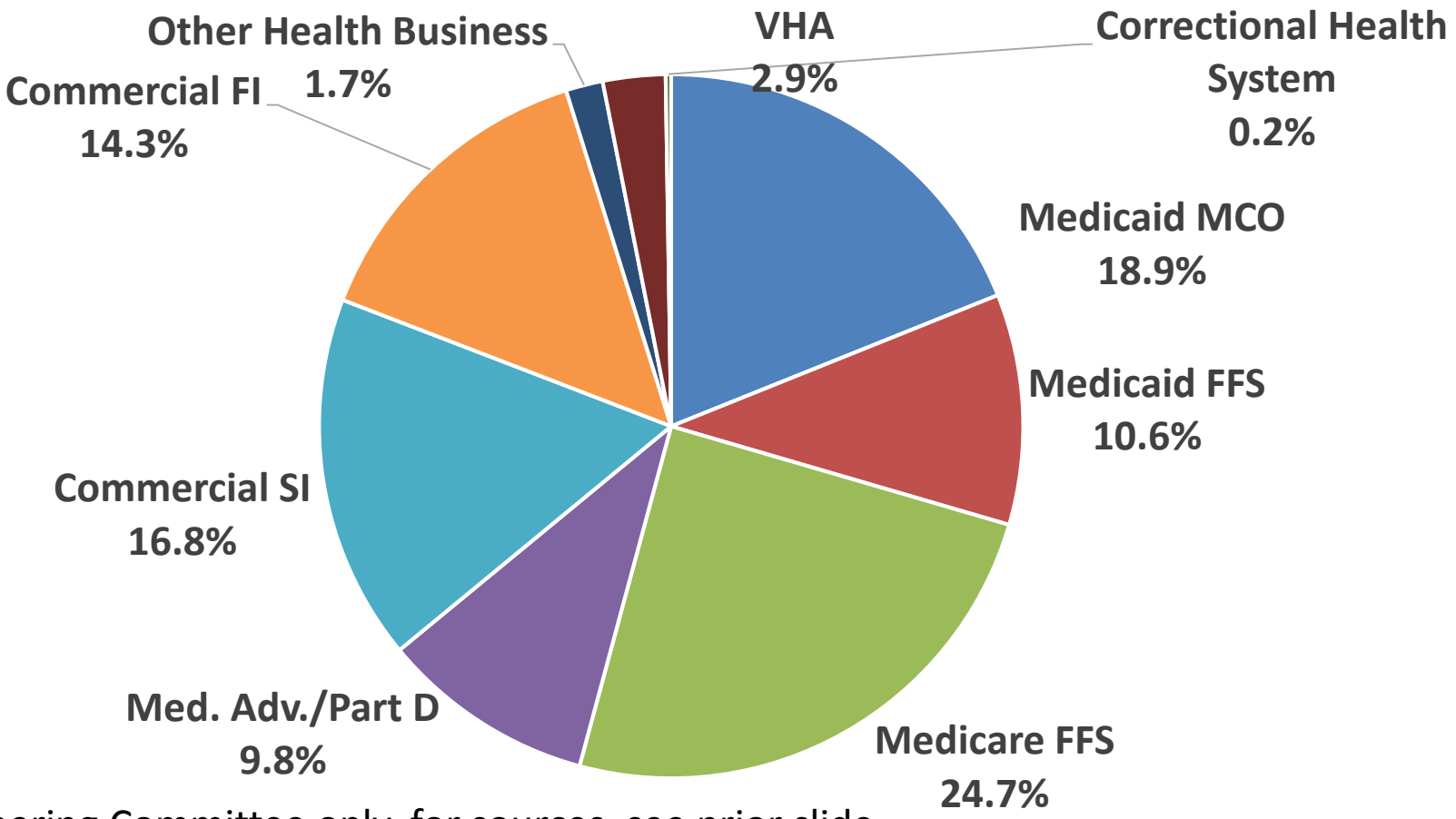
3. We have additional follow-up items from 9/17 that we'll complete in advance of the next meeting on 10/15.

Data Sources for Health Care Spending by Payer Category

- To better understand what categories of spending should be included in the target, the Steering Committee asked for information about health care spending across Rhode Island.
- Data were collected from a variety of sources and some estimates were made. Some spending may not be captured by this estimate.

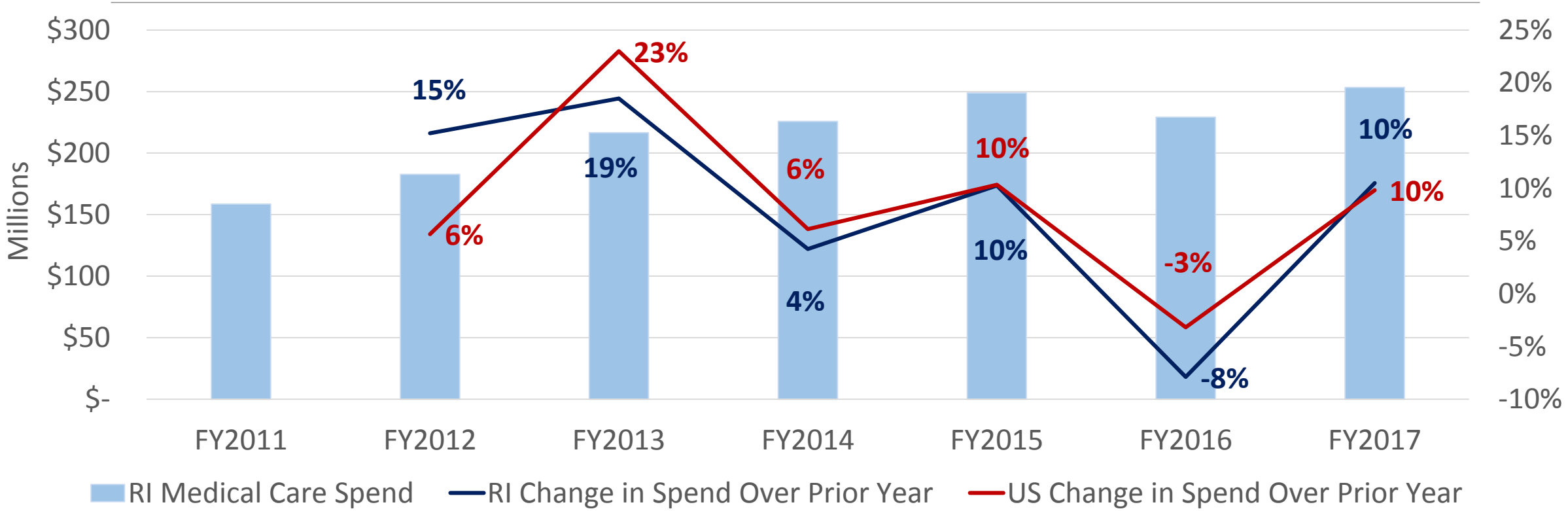
Payer Category	Data Year	Data Sources
Medicaid Managed Care + FFS	SFY2017	EOHHS. Rhode Island Annual Medicaid Expenditure Report.
Medicare FFS	2014	CMS. Medicare State Estimates by State of Residence (1991-2014) - Personal Health Care.
Commercial FI, Other Health Business, and Med Adv./Part D	2017	NAIC. Supplemental Health Care Exhibit Part 1 for the four major insurers in Rhode Island.
Commercial SI	N/A	Data were not available for commercial SI, so an estimate was created using commercial FI data and the fact that SI comprised 54% of the commercial population in 2017. Assumed per member spending was the same for SI and FI.
VHA	FY2017	National Center for Veterans Analysis and Statistics. Expenditures.
Correctional health system	FY2015	Pew. Prison Health Care: Costs and Quality.

Annual RI Health Care Spending by Payer Category (Estimate)



Estimate for use by the Steering Committee only, for sources, see prior slide

VA Medical Care Expenditures in Rhode Island

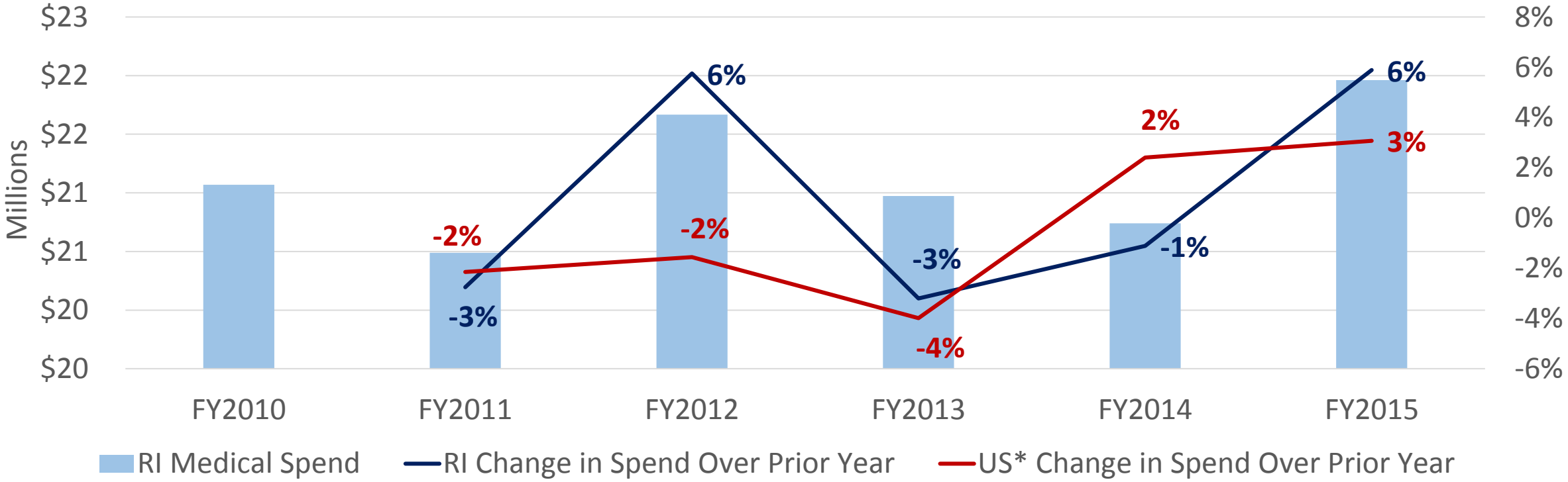


*This publicly available data allocates individual spending to the patient's home location, not the site of care. Therefore, this data could include Rhode Island Veterans receiving care in MA.

Source: https://www.va.gov/vetdata/expenditures.asp

Correctional Health System Medical Care Expenditures in Rhode Island

Spending is funded by state or federal funds and includes health care provided to individuals under the jurisdiction of the corrections department.



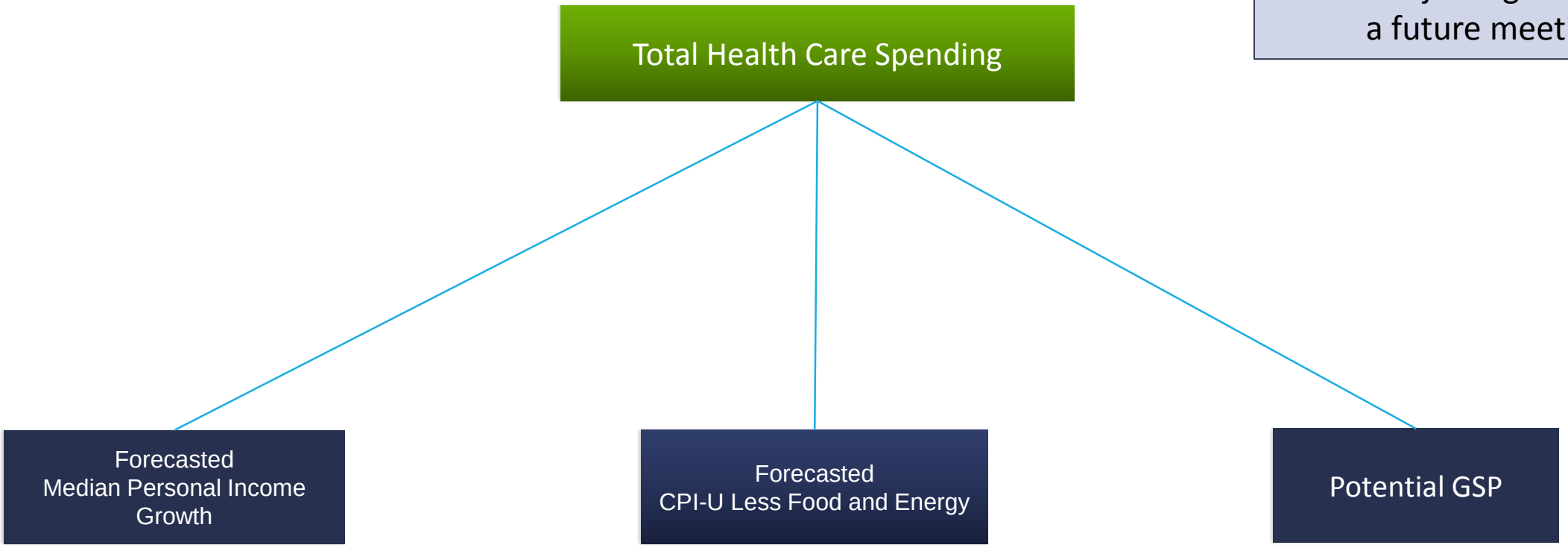
*US trend excludes NH and ND who did not provide complete data to Pew.
Source: https://www.pewtrusts.org/~/media/assets/2017/10/sfh_prison_health_care_costs_and_quality_final.pdf

Target Methodology Consideration: Economic and Consumer Impact

- The Steering Committee discussed at length whether to consider health care spending growth relative to economic growth or a measure of consumer affordability.
  - Steering Committee members wondered whether there could be two targets, or one target for two purposes.
- We created a straw model for the Steering Committee to review. In doing so, we narrowed the options down to one target focused on overall health care spending growth.
  - Measuring consumer affordability (through out-of-pocket spending) is heavily influenced by benefit design.
  - Two targets would be immensely more complicated to administer.
  - While consumer affordability is important, our focus is on reducing the overall rate of spending in the state.

Straw Models

Remember: there is value in having this conversation in absence of knowing the target number. We have time to debate adjusting the target at a future meeting.



Straw Model Options

ECONOMIC INDICATOR	PROS	CONS
Gross State Product	• Sets expectation that health care shouldn't grow faster than the overall economy	• Consumers view health care cost as any other cost • Doesn't address high degree of waste in current spending
Personal Income	• Sets expectation that health care shouldn't grow more than personal income – a more consumer-centric concept than GSP	• Similar to Gross State Product • Does not capture all sources of personal income, e.g., capital gains
Consumer Price Index All Items – Less Food and Energy	• Sets expectation that health care shouldn't grow faster than other consumer costs • CPI-U Less Food and Energy is more stable than CPI-U alone.	• Assesses health care on price only and does not consider service volume • Does not capture the significant effects of food and energy on consumer costs

Target Performance Assessment

Target Performance Assessment: Whose Performance is Being Assessed?

This topic is not about calculating the actual value of the target, but rather assessing performance relative to the target.

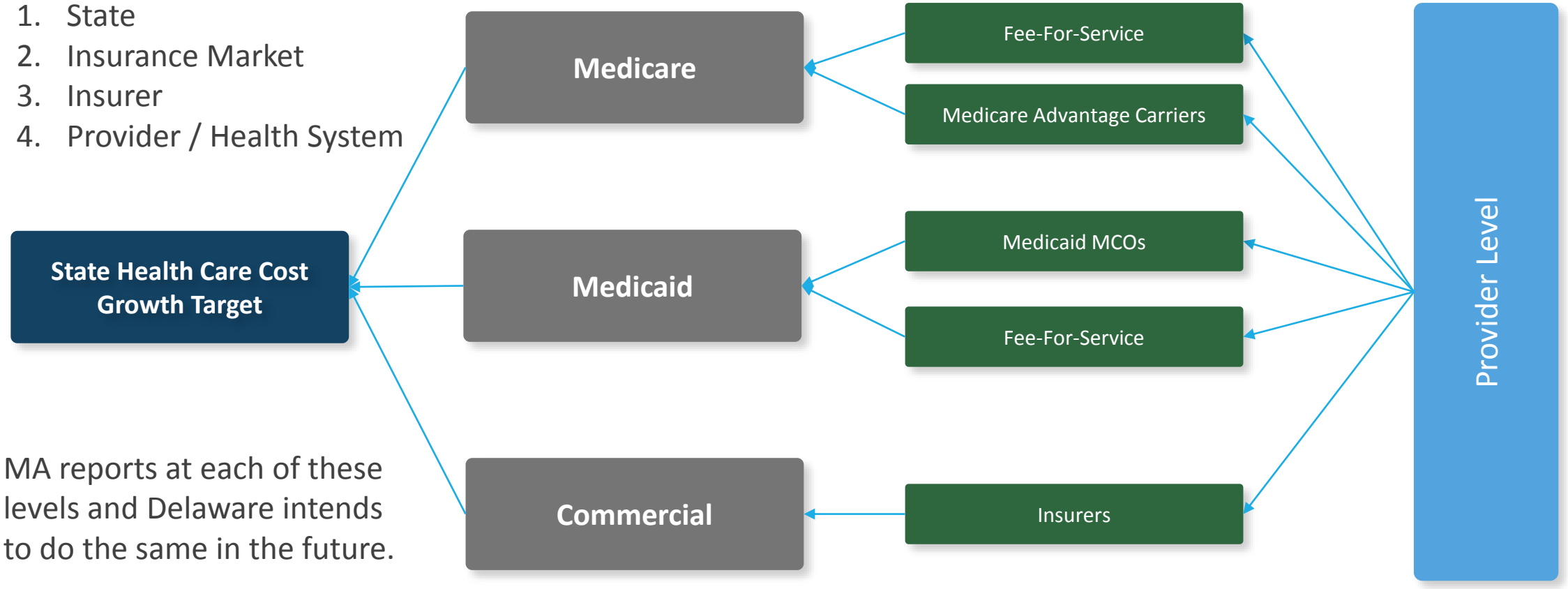
The key question to ask is what level should performance assessment take place?

There are four levels at which performance could be assessed. Rhode Island could choose to assess performance at one or any subset of each of the four levels.

They are…

Target Performance Assessment: Whose Performance is Being Assessed?

1. State
2. Insurance Market
3. Insurer
4. Provider / Health System



MA reports at each of these levels and Delaware intends to do the same in the future.

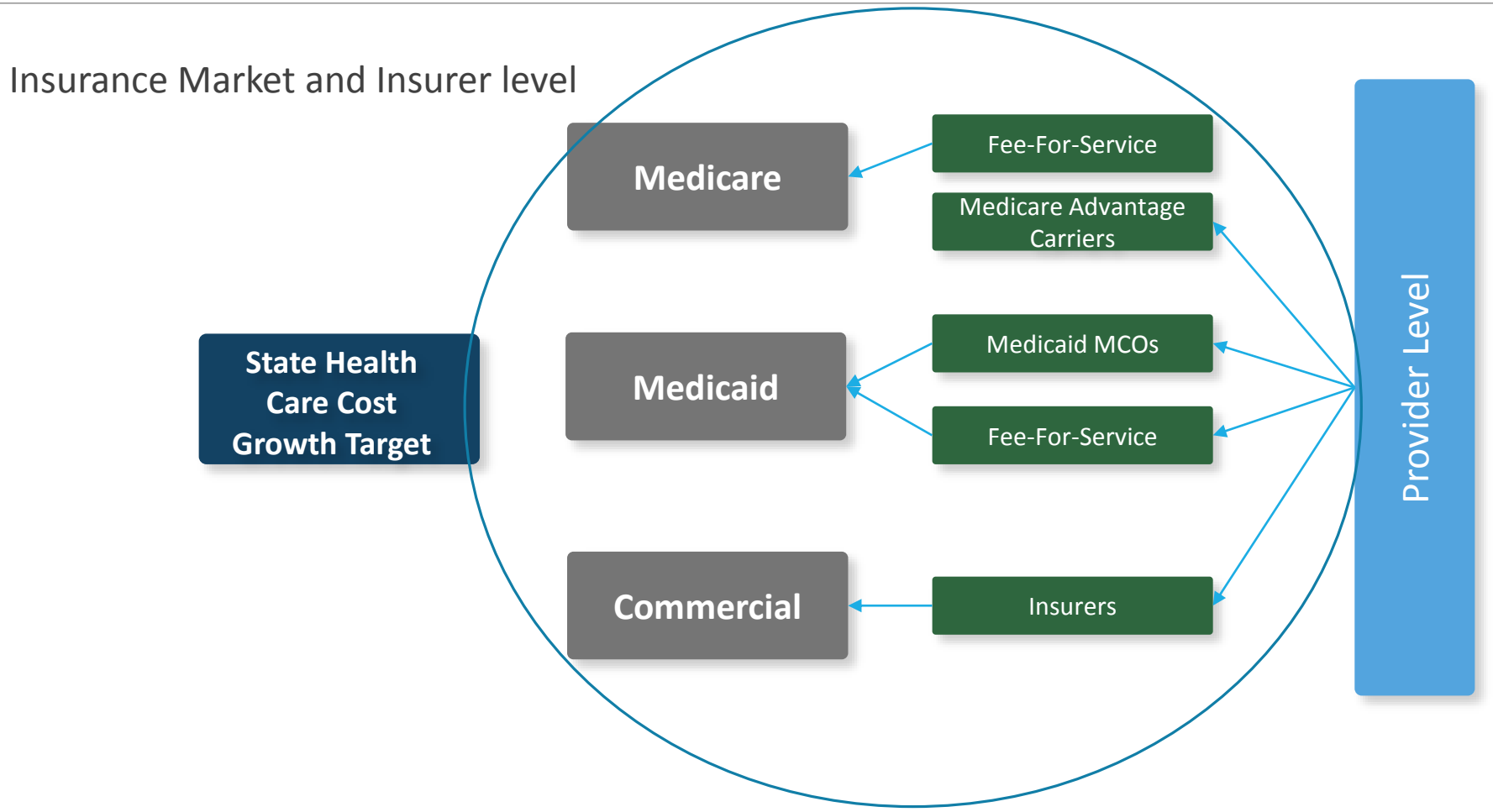
State Level

Reporting performance at the state level would combine all of the data on total health care expenditures and report one value for the state.

- One value for the state provides the total perspective, but reporting at the state level alone may not be sufficient. The health care market is too segmented and the experience of one sector may skew the state's figure up or down.
- One value for the state also anchors policymakers to a value that may not accurately reflect the experience of its constituents or individual markets.

Do Steering Committee members wish to recommend reporting at the state level? (We'll leave the questions about reporting at other levels for the moment).

Target Performance Assessment: Whose Performance is Being Assessed



Insurance Market and Insurer

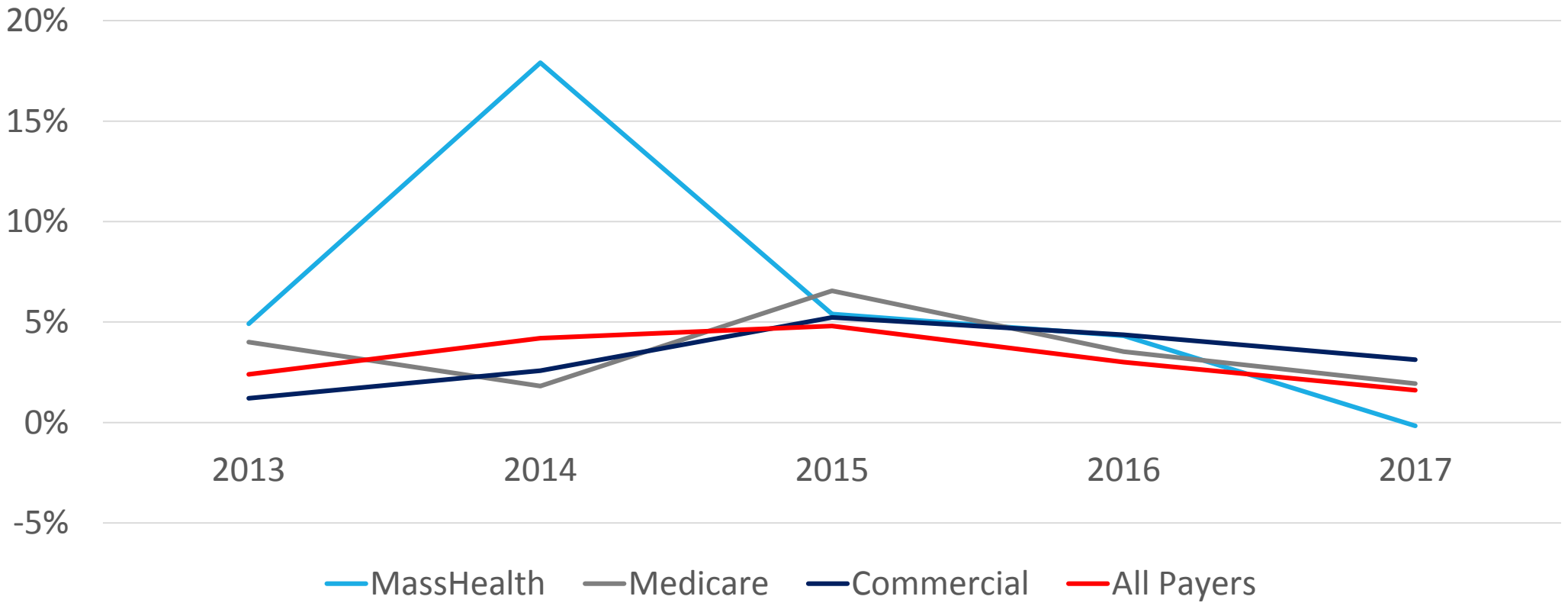
In order to report at the insurance market and insurer level, there are some considerations for Medicare and Medicaid.

- **Medicare:** To report spending by insurance market, Medicare would need to supply the state with data on its FFS population. Medicare can provide the State with spending on its FFS population, which is the majority of Medicare spending in the State.

- **Medicaid:** Should Medicaid report on spending by population group or solely in aggregate?

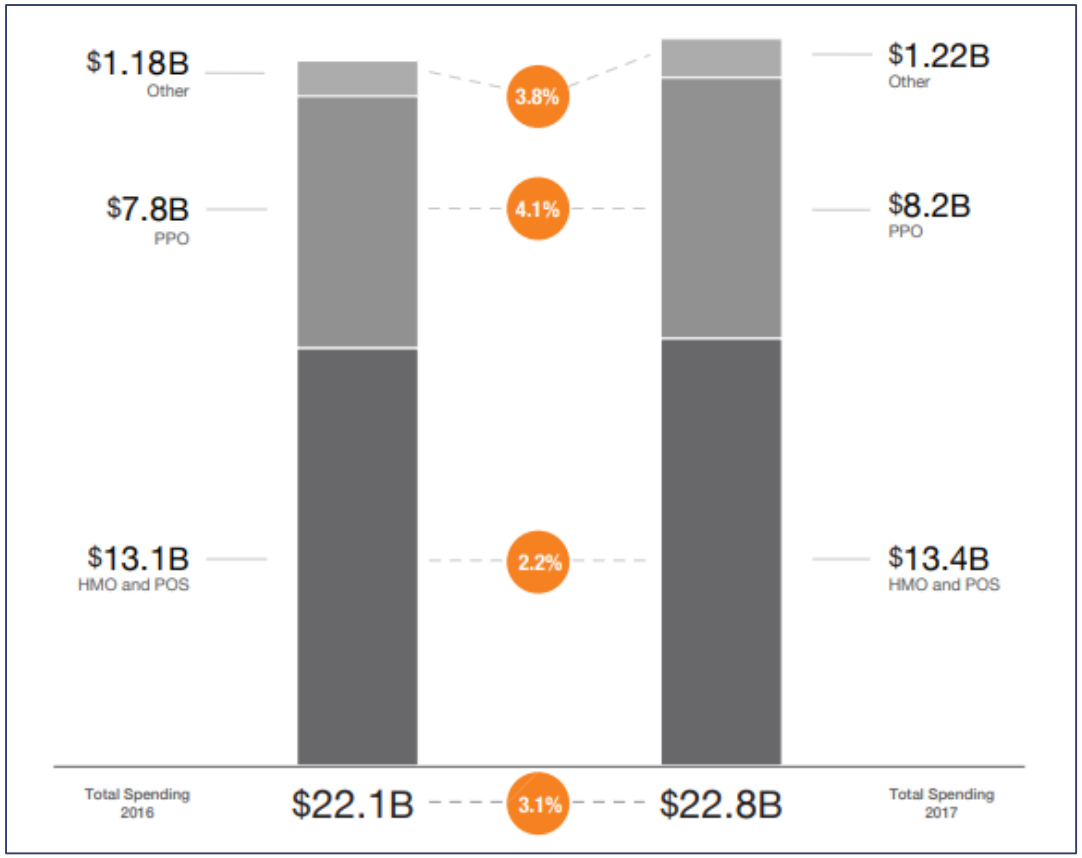
Do Steering Committee members recommend reporting be done at the insurance market level? What about insurer level?

Massachusetts Reports on Spending at the Insurance Market Level



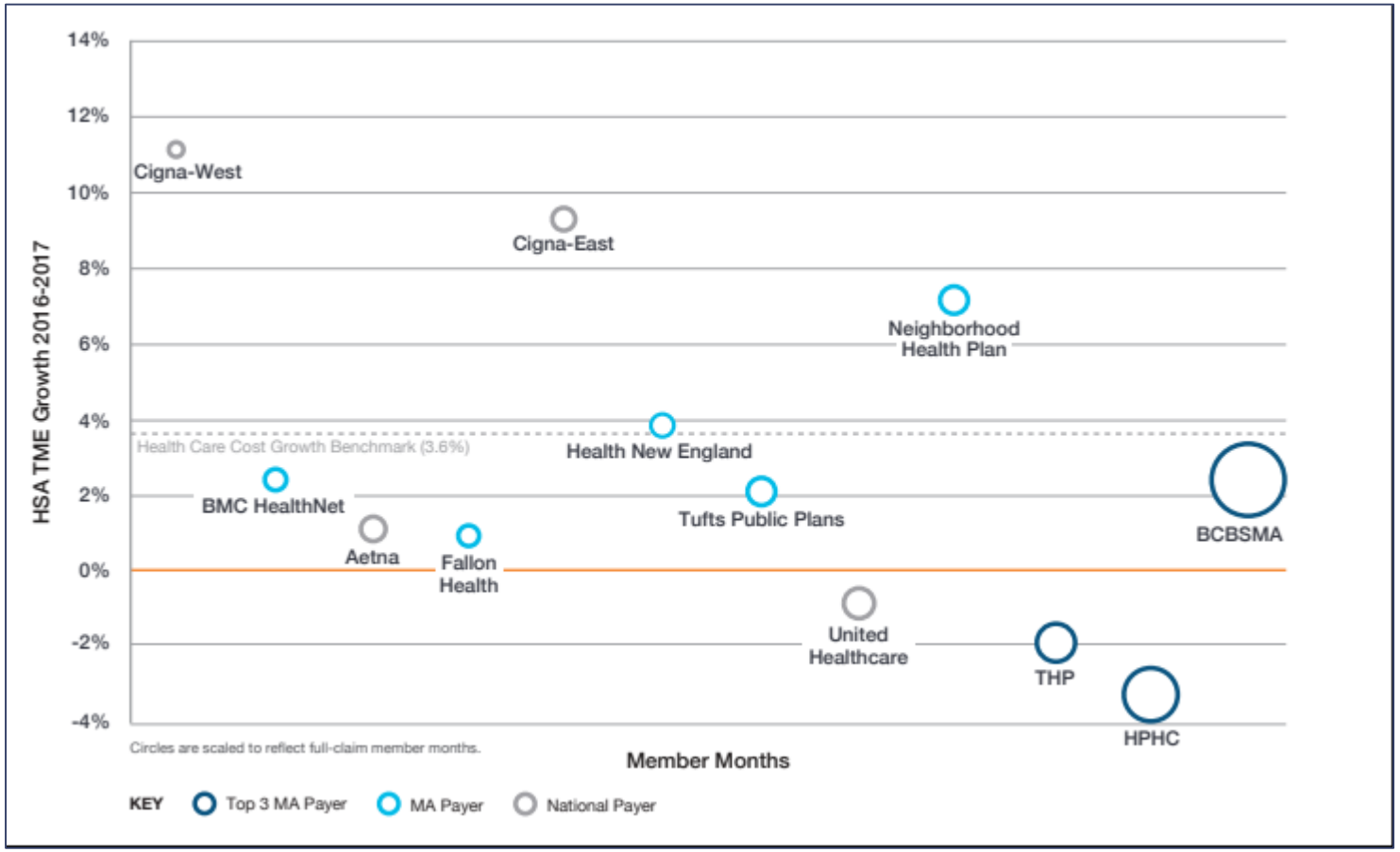
Sources: Center for Health Information and Analysis (CHIA) Performance of the Massachusetts Health Care System Annual Report, September 2018, September 2017, and September 2016.

Massachusetts Reports on Spending By Product Types Within Insurance Markets



Source: Center for Health Information and Analysis (CHIA) Performance of the Massachusetts Health Care System Annual Report, September 2018

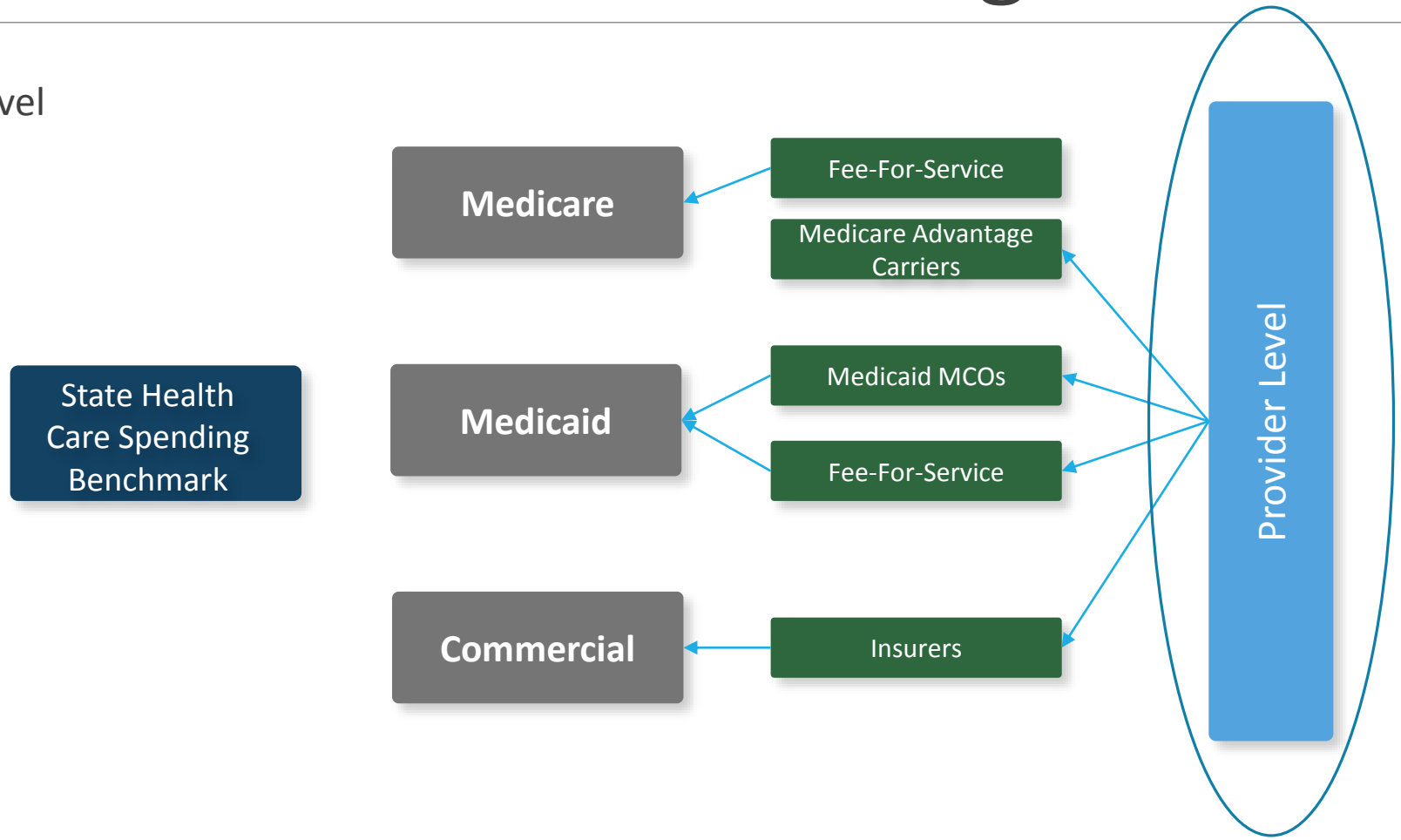
Massachusetts Measures Total Medical Expense Growth by Insurer



Source: Center for Health Information and Analysis (CHIA) Performance of the Massachusetts Health Care System Annual Report, September 2018

Target Performance Assessment: Whose Performance is Being Assessed

Provider level



Provider Level

In order to publish health care spending growth by provider, there are four questions that we must address:

1. What types of providers should be included?
2. How many attributed patients must a provider have for its health care spending growth rate to be calculated?
3. How will patients be attributed to those providers?
4. Does the difference in clinical risk across providers or changes in clinical risk attributed to one provider get adjusted, and if so, how?

Today, we will address questions 1 and 2. During the October 15th meeting, we will address questions 3 and 4.

What Types of Providers Should Have Their Performance Assessed?

Providers' whose performance is assessed must have enough attributable lives. Typically, providers with a sizable number of attributed lives include:

- ACOs
- Hospitals and health systems
- IPAs
- Medical groups with primary care, including FQHCs

Are there any other provider types that you would consider adding to this list? Are there any provider types on this list you would consider removing?

How Many Attributed Patients Must a Provider Have for its Health Care Spending Growth Rate to be Calculated?

To report on health care spending at the provider level, the provider needs to be sufficiently large enough to help dampen any “noise” in the data, and reduce the chance that random variation played a part in its performance.

What should the minimum patient volume be for providers who will have their performance measured against the target?

Massachusetts' Approach

Massachusetts publicly reports on health care spending relative to its cost target by provider organization.

Massachusetts reports performance relative to the target for the 10 largest provider organizations.

For other groups that still meet volume thresholds, CHIA confidentially reports to the Health Policy Commission any provider that is above the target, for one or more payers, so that the Health Policy Commission may conduct further analysis.

Massachusetts Provider Size

Insurers calculate and report by physician groups for which the insurer has 36,000 Massachusetts resident member months.

Member months:

- 12 member months is the equivalent of one member year, so 36,000 member months is equivalent to 3,000 member years.
- Insurers report data at the physician group level and at the physician group's parent organization level (if applicable).
- Insurers report data in aggregate at the insurer level only for contracted physician practices with fewer than 36,000 member months.

Authority and Governance

Key Topic: Authority and Governance

There are two central topics to discuss related to establishing and operationalizing the cost growth target.

- First, with what authority will the cost target be established?
- Second, what entity(ies) will operationalize the target?

We'll discuss each of these questions sequentially.

With What Authority Will the Cost Growth Target be Set?

How will the cost growth target will be established in policy?

There are four options to consider:

1. Governor issues an Executive Order
2. Legislature creates statute
3. OHIC uses regulatory power – but only affecting commercial lives
4. Voluntary compact among stakeholders

Are there other options that should be considered?

Authority Pros and Cons

Method	Pros	Cons
1. Executive Order	• Could be established quickly	• Could be rescinded easily by future administrations • Limitations in executive branch authority create constraints
2. Statute	• Authority would be established in law making it more difficult to change policy.	• Political negotiations could change policy intention • Legislature could choose to not act at all

MA's Approach

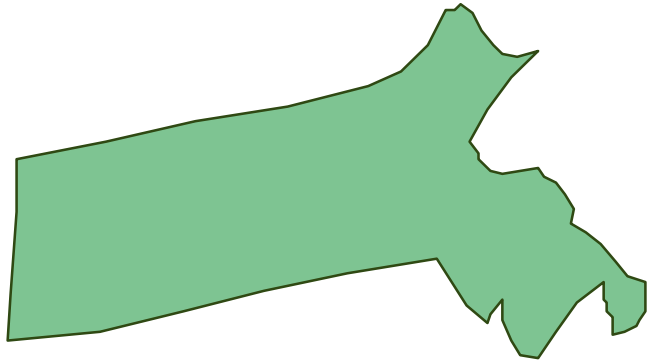
Authority Pros and Cons

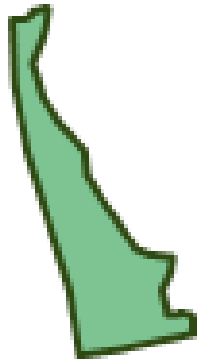
We will talk about implications for failure to meet the target during the next meeting.

Method	Pros	Cons
3. OHIC Regulations	• Could be established relatively quickly by OHIC	• Would represent a cap and not a cost growth target.
4. Voluntary Compact	• Creates high engagement among stakeholders	• Voluntary compacts can fall apart when priorities change or leaders change. • Less impetus for stakeholder to meet the target than with other strategy options.

What Entity(ies) Will Operationalize the Target?

In Massachusetts and Delaware there are organizations where setting and assessing the cost growth target is a natural fit.





- Legislature (sets the target)
- Center for Health Information and Analysis (assesses performance)
- Health Policy Commission (provides oversight)

- Delaware has proposed using it's Health Care Commission and its Delaware Financial Advisory Committee in some fashion for setting and assessing performance.

Rhode Island does not have such natural organizations.

What Entity(ies) Will Operationalize the Target?

Let's break down the conversation into two parts.

1. Which entity will set the target?
2. Which entity will assess performance against the target?

Entity Setting the Target?

The target could be set by:

1. The Governor
2. The Legislature
3. EOHHS
4. OHIC

Are there other entities that could possibly set the target? Do the Steering Committee members have preference or concerns about any of these entities setting the target?

Entity Assessing Performance?

Performance against the target requires an organization that could obtain data and analyze it. Some entities might include:

1. EOHHS
2. OHIC
3. Other public or non-profit institution in the state

Are there other entities that could possibly assess the performance? Do the Steering Committee members have preference or concerns about any of these entities assessing performance?

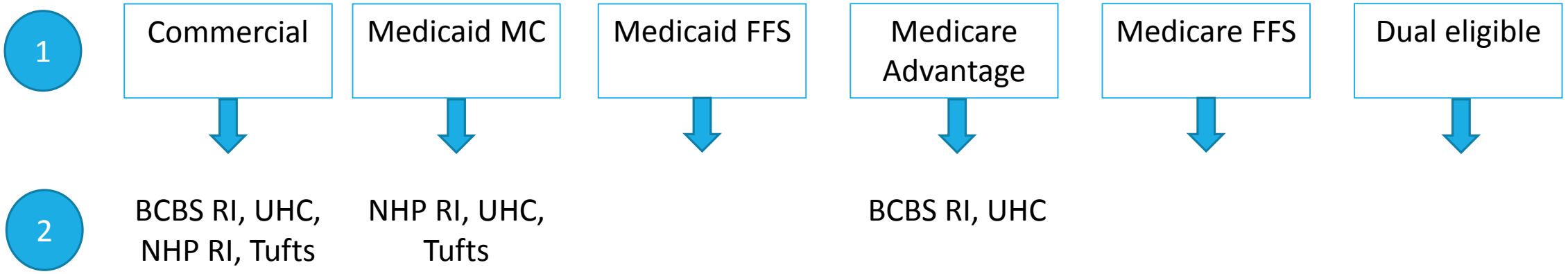
Funding Sustainability

Resources are required to sustainably maintain the cost growth target and associated analyses.

This is an important conversation for us to have, but we will defer it to a future meeting.

Data Analysis Work Stream: Patient Attribution

Patient attribution to payer type and health plan



- Attributed on monthly basis
- Based on enrollment start and end dates using monthly member files in APCD
- Attributed to payer type and health plan in which member had majority of member days in prior month, weighted by number of member days

Patient attribution to providers

(1) Patient attributed to PCP → (2) *PCP attributed to provider group* → (3) *Patient attributed to PCP's provider group*

Patient attribution to PCP

- Attributed on monthly basis
- Assign patient to PCP providing majority of primary care visits in previous 24 months; assign to most recent if tie
- What qualifies as a PCP visit?
  - Outpatient or professional claim;
  - CPT-4 code for evaluation and management services, domiciliary or rest home care, home visit, preventive medicine services, and/or an annual wellness visit; and
  - PCP specialty is family or general practice, internal medicine, nurse practitioner (practicing with PCP), physician's assistant (practicing with PCP), pediatrics, or geriatrics; an FQHC may also serve as a PCP.

PCP attribution to provider group

- Provider group attribution to be done for 2017 only
- Link PCP NPIs and/or TINs to external provider directories (medical groups, ACOs)
  - Need access to data from plans and/or ACOs on which PCPs and specialists are included in ACO contracts
- Which provider groups to include in medical groups
  - How to best define?
  - Which to include and exclude?

Public Comment Period

Wrap-Up and Next Meetings

All meetings are Mondays from 9:00 a.m.-12:00 p.m.

October 15	301 Metro Center Blvd, Suite 203, Warwick, RI 02886
October 22	301 Metro Center Blvd, Suite 203, Warwick, RI 02886
November 5	301 Metro Center Blvd, Suite 203, Warwick, RI 02886
November 26	301 Metro Center Blvd, Suite 203, Warwick, RI 02886
December 10	301 Metro Center Blvd, Suite 203, Warwick, RI 02886