Rhode Island Health Care Cost Trends Project Steering Committee

Rhode Island Health Care Cost Growth Target
Cost Growth Target Recommendations
November 27, 2018

I. Introduction

In August 2018, the Rhode Island Executive Office of Health and Human Services, the Office of the Health Insurance Commissioner, and the Governor's Office first convened a Health Care Cost Trends Steering Committee (Steering Committee) with funding from the Peterson Center on Healthcare. The Steering Committee is comprised of 18 diverse Rhode Island stakeholders, representing government, business and community leaders, for the purpose of advising the OHIC, EOHHS, and the Governor on cost growth target recommendations, including methods for:

1. establishing an annual health care cost growth target;
2. measuring and reporting on the total cost[1] of health care in Rhode Island, and
3. analyzing and reporting performance relative to the target.[2]

The Steering Committee has met six times between August 29, 2018 and November 26, 2018. This document puts forth the Steering Committee's recommendations for 2019 implementation of a Rhode Island cost growth target.

II. Methodology to Establish an Annual Health Care Cost Growth Target

A cost growth target is a percentage by which Rhode Island's total health care spending should annually grow no faster. The Steering Committee considered multiple economic indices as the basis for defining the Rhode Island health care cost growth target. The recommended index and its use follow below.

- **Economic Indicator:** The cost growth target should be the value of Rhode Island's Potential Gross State Product (PGSP). PGSP is the total value of the goods produced and services provided in a state at a constant inflation rate. It is calculated as follows:

Calc.	Element	Value	Source
	Growth in the Potential Labor Force Productivity	1.4%	The source is the most recently published Congressional Budget Office Budget and Economic Outlook Report.[3] Included within the report is a table of Key Inputs in the

[1] "Cost" is used as a synonym for "spending" in this document. Both terms refer to expenditures made to providers by consumers, employers, insurers and government agencies.
[2] Transparency of performance is the sole intended consequence of performance relative to the cost growth target.
[3] As of September 20, 2018, the Congressional Budget Office published its Budget and Economic Outlook Reports here: www.cbo.gov/about/products/major-recurring-reports#1.

Calc.	Element	Value	Source
			CBO's Projections of Real Potential GDP that includes the potential labor force productivity projected average annual growth from 2023–2028 (Page 13, Table 2 of the August 2018 report). In general, the figure used to calculate PGSP should be the value that is forecast for five through 10 years into the future.
+	Potential Labor Force Growth	0.0%	Rhode Island Office of Management and Budget purchased forecast from IHS Economics.
+	Forecasted Inflation	2.0%	The source is the most recently published Congressional Budget Office Budget and Economic Outlook Report.[4] Included within the report is a table of CBO's Economic Projections for Calendar Years 2018 to 2028 (Page 5, Table 1 of the August 2018 report). In general, the figure used to calculate PGSP should be the value of the "PCE price index" percentage change from year-to-year that is forecast for five through 10 years into the future.
-	State Population Growth	0.2%	The source is the Rhode Island Population Projections Summary Tables from the Division of Statewide Planning. In general, the figure used to calculate PGSP should be the percentage change from year-to-year that is forecast for five through 10 years into the future. In this case, because the Division of Statewide Planning provides forecasts in five-year bands, the calculation used the figures that were as close to five through 10 years into the future. Specifically, the figure used to calculate PGSP is the annualized growth rate between 2025 and 2030.
=	**Rhode Island PGSP**	**3.2%**	The calculation consists of the sum of the expected growth in national labor force productivity, plus the expected growth in Rhode Island's labor force, plus the expected national inflation; minus Rhode Island's expected population growth.

- **Target Duration:** The target's duration should be four years, i.e., 2019 through 2022, and maintain the stable value of 3.2% throughout. During 2022, the State should revisit the methodology of the cost growth target and keep the existing or establish a new target for 2023 and beyond.

- **Periodic Review:** Significant changes in the economy should trigger re-visiting of the target methodology. The State should develop a functional definition of "significant changes" in consultation with the Steering Committee or a successor stakeholder body.

[4] As of September 20, 2018, the Congressional Budget Office published its Budget and Economic Outlook Reports here: www.cbo.gov/about/products/major-recurring-reports#1.

III. Methodology to Measure and Report on the Total Cost of Health Care in Rhode Island

The table below outlines recommended payer populations, states of residence and locations of care, and types of spending to be included in the measurement of Rhode Island's total health care spending. Spending should be calculated net of pharmacy rebates.

Methodological Consideration	Include	Exclude
Payer Populations*	• Commercial (both fully insured and self-insured populations), • Medicaid • Medicare	• Correctional Health • TRICARE • Veteran's Health Administration
States of Residence and Locations of Care	• Rhode Island residents with Rhode Island providers • Rhode Island residents with out-of-state providers	• Out-of-state residents with Rhode Island providers • Out-of-state residents with out-of-state providers
Types of Spending	• Claims-based spending • Non-claims-based spending • Pharmacy carveouts	• Behavioral health carveouts

*Provider resources applied in the delivery of care for uninsured Rhode Islanders should not be included in calculations of health care spending because they are technically not "spending" as defined herein. Future reporting on spending relative to the target should, however, indicate that while these resource applications are not captured in the measurement of total health care spending, they may be significant for certain providers.

IV. How to Analyze Performance Relative to the Target

The Steering Committee discussed the levels at which accountability will be measured, and how calculations of performance should be made.

- **Level of Performance:** Performance against the cost growth target should be assessed at the 1) state, 2) insurance market, 3) insurer, and 4) large provider organization levels.

- **Data Source:** The data source used to assess performance relative to the target should be determined prior to 2020. The State should complete ongoing research into whether the state's APCD can be used as a data source, with payer supplementation, or whether the use of payer-reported calculations would be a preferable data source.

- **Risk Adjustment:** Assessment of payer and provider performance relative to the target should be adjusted for annual changes in population clinical risk. The approach to risk adjustment will depend on the data source. If the data source is solely payer-reported, then payers should use their existing risk-adjustment methodologies. If the data source is primarily the APCD with payer supplementation, a common risk adjuster should be used.

- **Provider-Level Reporting:**
  - Provider-Level Attribution: The data source will ultimately determine how patient attribution should be done. If the data source will primarily be the APCD, then patient attribution will be done across payers by line of business, meaning that an ACO will have one attributed population for each of commercial, Medicaid and

Medicare (as applicable). If the data source will primarily be payer-reported data, then patient attribution should be reported by payer and by line of business, meaning an ACO will have one attributed population for each line of business by each payer.

In addition:

- Patient attribution should be conducted at the ACO level by line of business for all attributable patients.
- For those providers in an ACO but without the minimum number of attributed lives required to report provider performance, their performance should be reported in aggregate in an "all other ACO" category calculated by line of business.
- For those providers not in an ACO, there should be an aggregate "all other providers" value calculated by line of business for all attributable patients.

- Minimum Number of Attributed Members Required to Report Provider Performance:
  - Commercial and Medicaid: Providers should have a minimum of 10,000 attributable member lives per year.
  - Medicare:[5] Providers should have a minimum of 5,000 attributable member lives per year.
- Performance Confidence Interval Bands: The State should develop guidelines for when to signify provider deviation from the cost growth target as statistically meaningful (not at high risk of influence by random variation) in consultation with the Steering Committee or a successor stakeholder body. This might entail additional analyses of the APCD to develop performance confidence interval bands. These confidence interval bands should be applied to provider reporting.

V. How to Report Performance Relative to the Target

The Steering Committee discussed how performance should be reported to the public.

- **Timeline for Reporting Performance:** Annually, performance data should be collected and analyzed in the year following the performance year. Results should be made public as soon as data are available and analyzed, but no later than the fourth quarter of the year following the performance year.
  - Should APCD data be used, results should be discussed with payers and providers prior to public dissemination.

VI. Establishment and Monitoring of the Health Care Cost Growth Target

The Steering Committee discussed the establishment of the cost growth target as well as what body should periodically review questions related to the cost growth target methodology and reporting.

[5] If the data source is primarily payer-reported, Medicare FFS members will be unattributable to an Rhode Island provider and provider performance on Medicare will not include the FFS population.

- **Establishment:** The parameters of the cost growth target should be established in a compact signed by the members of the Steering Committee in conjunction with an executive order, referencing the terms of the compact with respect to the cost growth target and directing state agencies to assign resources needed to support data collection, analysis and public reporting related to assessment of performance relative to the cost growth target. At a future time, the State should consider legislation to ensure necessary funding to support ongoing authorization and operations of cost growth target-related activities.

- **Monitoring:** The Steering Committee should serve as the advisory body to the State for methodological and reporting questions related to the cost growth target. The State should consider the potential addition of members to the Steering Committee to voice perspectives not currently represented.

VII. Relationship between OHIC's Hospital Price and ACO Budget Growth Caps and the Health Care Cost Growth Target

The Steering Committee did not address the relationship between OHIC's hospital price and ACO budget growth caps and the cost growth target. The Steering Committee recommends that the State give attention to this relationship in the future.