Rhode Island Health Care Cost Trends Steering Committee

January 26, 2022

Agenda

1. Welcome and Introduction
2. Approve October Meeting Minutes
3. Sustainability
4. VBP Subcommittee Work to Date
5. Public Reporting of Quality Measures
6. Cost Growth Target Activities in Other States
7. Public Comment
8. Next Steps and Wrap-up

Welcome

Approval of Meeting Minutes

Approval of Meeting Minutes

- Project staff shared minutes from the October 18th Steering Committee meeting in advance of the meeting.
- **Does the Steering Committee wish to approve the October meeting minutes?**

Sustainability

Funding Future Work

- Governor McKee, as a part of his state fiscal year 2023 budget proposal, has proposed $500,000 for the Health Spending Accountability and Transparency Program at OHIC.

- The Health Spending Accountability and Transparency Program proposed has three key goals that are designed to curb health care spending growth:
  - Goal 1: Understand and create transparency around what drives cost growth
  - Goal 2: Create shared accountability for cost growth among payers, providers, and government
  - Goal 3: Lessen the negative impact of rising health care costs on Rhode Island residents, businesses, and government purchasers

Funding Future Work

- OHIC, with input from the Rhode Island Health Care Cost Trends Steering Committee comprised of representatives from the health care community, businesses, and consumers, will oversee the program.

- Preliminary work to create the program has been conducted by OHIC and funded by philanthropic organizations.

- The request will provide a funding source to ensure that the work continues.

Legislative Strategy

- During our last Steering Committee meeting, there was agreement that greater legislator engagement would be critical to long-term sustainability.
- Denterlein's research suggested that legislator engagement should include explaining that *solutions to lack of affordability are possible* and the Cost Trends Project will:
  - positively affect constituents by freeing up funds for other personal, public and organizational uses
  - improve the health of Rhode Islanders and reduce disparities through complementary strategies such as enhanced VBP that will improve care delivery

Communication Tools

- To improve the effectiveness of legislator and other stakeholder engagement, Denterlein has or will be creating the following resources:
  - standard PowerPoint presentation
  - Q&A document
  - Cost Trends microsite to site within the OHIC website

VBP Subcommittee Work to Date

VBP Subcommittee Work

- The VBP Subcommittee most recently met on November 30th and December 10th.
- So far, the Subcommittee has:
  - defined principles to underlie a future VBP compact
  - begun drafting a VBP compact
  - identified barriers to adoption of advanced VBP
  - identified potential strategies to address those barriers
  - considered a first draft straw model for a compact strategy

VBP Subcommittee: Principles

1. Prospective budget-based payment, with quality-linked financial implications, should be the primary advanced VBP model utilized for all provider types wherever feasible.
2. Where prospective budget-based payment is not feasible, alternatives such as (1) adjusted FFS payment to meet a prospective budget and (2) retrospectively reconciled budget-based FFS payment that includes both shared savings and downside risk should be adopted.
3. Advanced VBP models should support:
   - improved patient experience of care;
   - improved quality of care;
   - positive patient outcomes;
   - improved health equity, and
   - anticipate and mitigate negative unintended consequences.

VBP Subcommittee: Principles

4. Payers should make available a common menu of advanced VBP models to allow providers to have a sufficient volume of similar value-based arrangements, recognizing the need for some differences due to varying plan market share. In addition, the design features of the advanced VBP models should be aligned on selected elements where alignment would reduce provider administrative cost.
5. A foundation of robust primary care is essential for advanced VBP model success.
6. Employers, payers, and providers should encourage selection a primary care provider (PCP), whether or not required by benefit design, to support advanced VBP model effectiveness.
7. Specialty care providers should be integrated into advanced VBP models.

VBP Subcommittee: Principles

8. Cross-organizational provider relationships should be encouraged to promote efficiency and to avoid unnecessary service duplication.
9. There should be rigorous analysis of new model implementation from the beginning.
10. The pace of advanced VBP model adoption may be slowed in the short-term by coronavirus disease 2019 but the pace must later accelerate to compensate.

VBP Subcommittee Work: Straw Model

The straw model is comprised of the following:

1. Continued shared risk contracts between payers and ACOs and AEs.
2. Statewide application of the following payment models:
   - All-payer hospital global budget for facility and employed professional services
   - All-payer primary care prospective payment
   - All-payer advanced VBP for high-volume, high-cost non-hospital-employed specialty services (e.g., behavioral health, orthopedics, imaging, etc.).
3. Alignment with the Subcommittee's endorsed principles.

While there remain many details to be worked out, Subcommittee members expressed support for further developing the straw model and enthusiasm for an educational webinar on hospital global budgets in early January.

VBP Subcommittee Work

- OHIC has scheduled the next Subcommittee meeting for January 31st.
- The Subcommittee's final deliverable will be a compact that outlines targets, timelines and accountable parties to ensure transformation of RI health care payment in a manner that will support future cost growth target attainment.

VBP Subcommittee Work: Webinar on Hospital Global Budgets

- OHIC repurposed the VBP Subcommittee meeting intended for January 10th for an educational webinar on hospital global budgets. The meeting was recorded.
- Guest speakers were national hospital global budget expert Bob Murray and former Maryland hospital executive Patrick Dooley.
  - Bob offered a flexible global budget approach that could potentially work in Rhode Island, while Patrick described Maryland's hospital experience with hospital global budgets.

Public Reporting of Quality Measures

Public Reporting of Quality Measures

- The Steering Committee has periodically discussed in the past whether at some point reporting of cost growth performance relative to the target should be complemented by a consideration of quality.
  - Heretofore, the majority opinion has been that priority focus should remain on arresting health care spending growth.
  - The Steering Committee has not revisited the question of measuring and reporting quality performance for some time.

Public Reporting of Quality Measures

- The co-chairs now believe there is merit in publicly reporting on quality performance to complement cost trend reporting.
  - Reporting would occur at the insurance market, insurer and ACO/AE levels (commercial and Medicaid only).
  - ACO/AE commercial and Medicaid performance would be reported separately. There would be no reporting of Medicare performance since such data are not easily accessible.
  - Insurers would provide necessary data to OHIC.
  - Reporting would begin in 2023 for CY2021 performance.

Public Reporting of Quality Measures

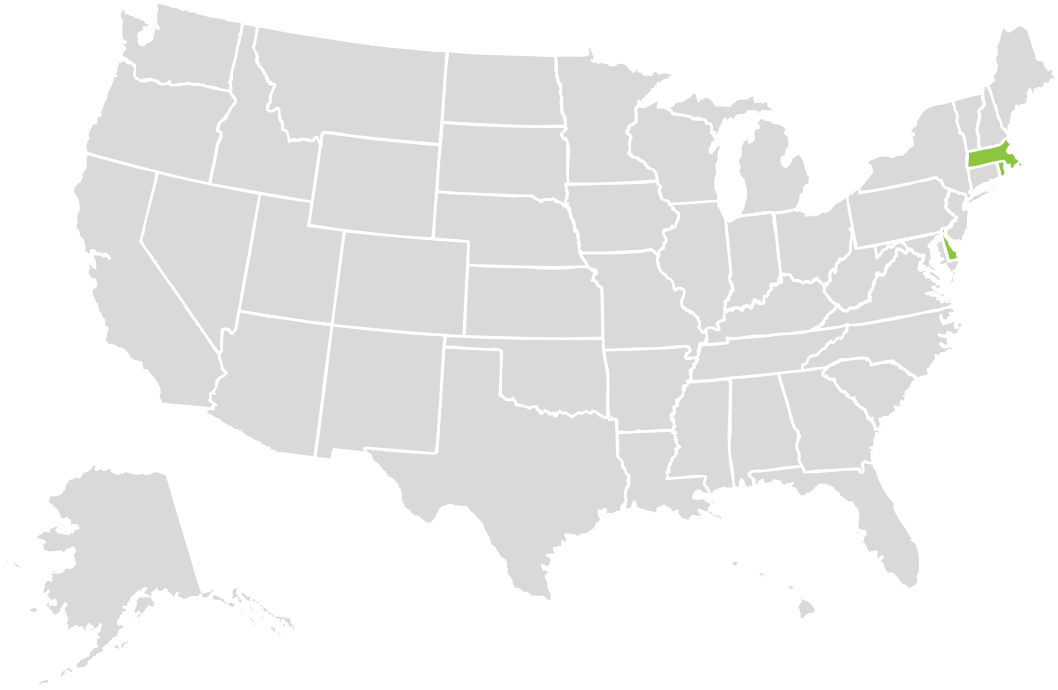
- The co-chairs propose starting reporting with the Core Measures in the OHIC ACO Aligned Measure Set.
- The 2023 Core Measures include:
  - Adolescent Well-Care Visits
  - Breast Cancer Screening
  - Colorectal Cancer Screening
  - Controlling High Blood Pressure
  - Developmental Screening ion the First Three Years of Life
  - Eye Exam for Patients with Diabetes
  - Follow-up After Hospitalization for Mental Illness (7-Day)
  - Hemoglobin A1c Control for Patients with Diabetes (<8.0%)

Public Reporting of Quality Measures

- Does the Steering Committee recommend asking insurers to report on ACO/AE quality for these Core Measures?
  - Pros: Elevates quality as a parallel priority, makes use of available data at little cost
  - Cons: Limited number of measures, ACO/AE-level data are not audited for accuracy, new requirement of insurers

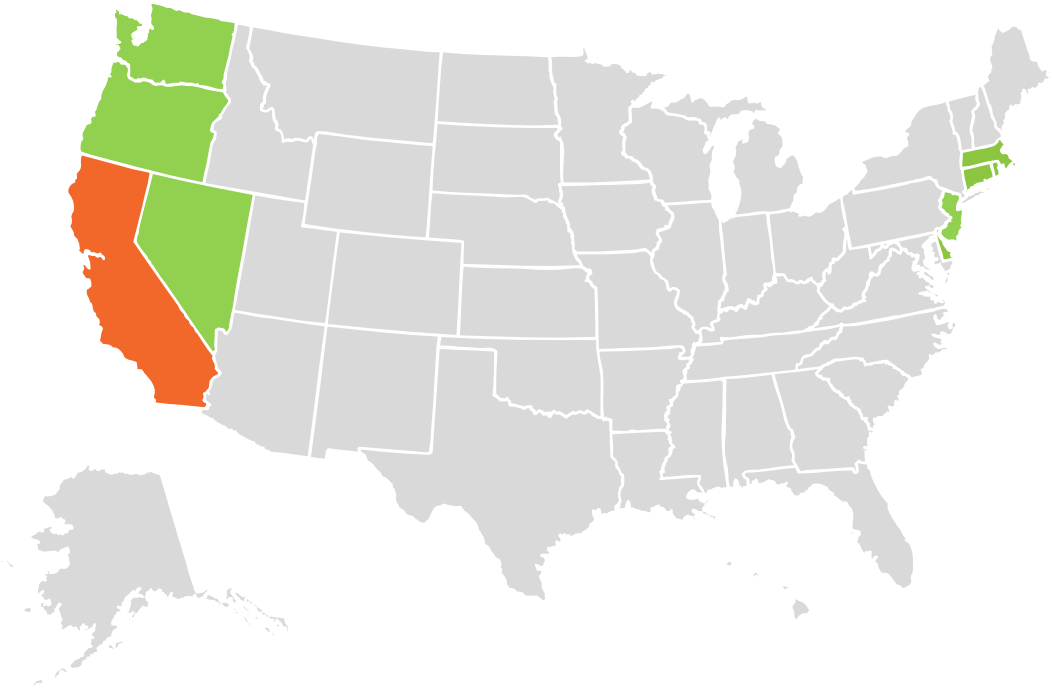
Cost Growth Target Work in Other States

State Activity on Health Care Cost Growth Targets: Two Years Ago



Established (DE, MA, RI)

State Activity on Health Care Cost Growth Targets: Today



Established

Active discussions underway

Cost Growth Target Values in Other States

State	Cost Growth Target / Benchmark Values
Connecticut	3.4% for 2021 3.2% for 2022 2.9% for 2023-2025
Delaware	3.8% for 2019 3.5% for 2020 3.25% for 2021 3.0% for 2022-2023
Massachusetts	3.6% for 2013-2017 3.1% for 2018-2022
Nevada	3.19% for 2022 2.98% for 2023 2.78% for 2024 2.58% for 2025 2.37% for 2026

State	Cost Growth Target / Benchmark Values
New Jersey	3.5% for 2023 3.2% for 2024 3.0% for 2025 2.8% for 2026 2.8% for 2027
Oregon	3.4% for 2021-2025 3.0% for 2026-2030
Washington	3.2% for 2022-2023 3.0% for 2024-2025 2.8% for 2026

A New State Focus on Affordability

Examples of a new state focus on health care affordability over the past two years, particularly for the commercial market:

- California: Office of Health Care Affordability (proposed)
- Colorado: Office of Saving People Money on Health Care
- Delaware: Office of Value-Based Health Care Delivery
- Maine: Office of Affordable Health Care
- New Jersey: Health Care Affordability Advisory Group
- Vermont: Legislative Task Force on Affordable, Accessible Health Care

What else are the states doing?

- **Oregon**
  - Like Rhode Island, has a stakeholder body working on a VBP strategy and compact.
  - Adopted accountability measures for exceeding the cost growth target for unjustified reasons: first a performance improvement plan, and then financial penalties for exceeding the target repeatedly.
  - Holding annual cost hearings starting this December and modeled off Massachusetts' annual practice.

What else are the states doing?

- **Connecticut**
  - Publishing extensive APCD-based analyses of trends, cost drivers, and disparities, and bringing them to public meetings and to a stakeholder steering committee for discussion.
  - Implementing an all-payer primary care spend target and a primary care "roadmap" to support the states primary care infrastructure.
  - Establishing quality benchmarks effective 2022.

Medical spending PMPM increased 21%, 2015-19

Payer	2015	2016	2017	2018	2019	2016	2017	2018	2019	Total change (%)
All-payer (unadjusted)	$375.47	$407.64	$421.05	$431.19	$454.19	8.6%	3.3%	2.4%	5.3%	21.0%

Notes:
1) The average annual increase was 4.9%.
2) Average wage growth in CT for the same time period was 2.6%.
3) Limited to CT residents under age 65.
4) Excludes retail pharmacy spend, a major contributor to spending growth in other states.

Out-of-pocket spending increased much faster than total spending

Payer	OOP spending for insured medical services (PMPM)					Annual OOP change (%)				Average annual change (%)		Total change (%)	
	2015	2016	2017	2018	2019	2016	2017	2018	2019	OOP	PMPM	OOP	PMPM
All-payer (unadjusted)	$44.26	$47.82	$53.83	$55.25	$56.70	8.0%	12.6%	2.6%	2.6%	6.5%	4.9%	28.1%	21.0%

Note:

1) The average annual increase in out-of-pocket spending was 6.5%.
   - This includes patient co-insurance, deductible, and co-payment obligations. It does not include premium contributions.
2) This finding reflects changes in employer decisions on plan design, and employee plan selection.

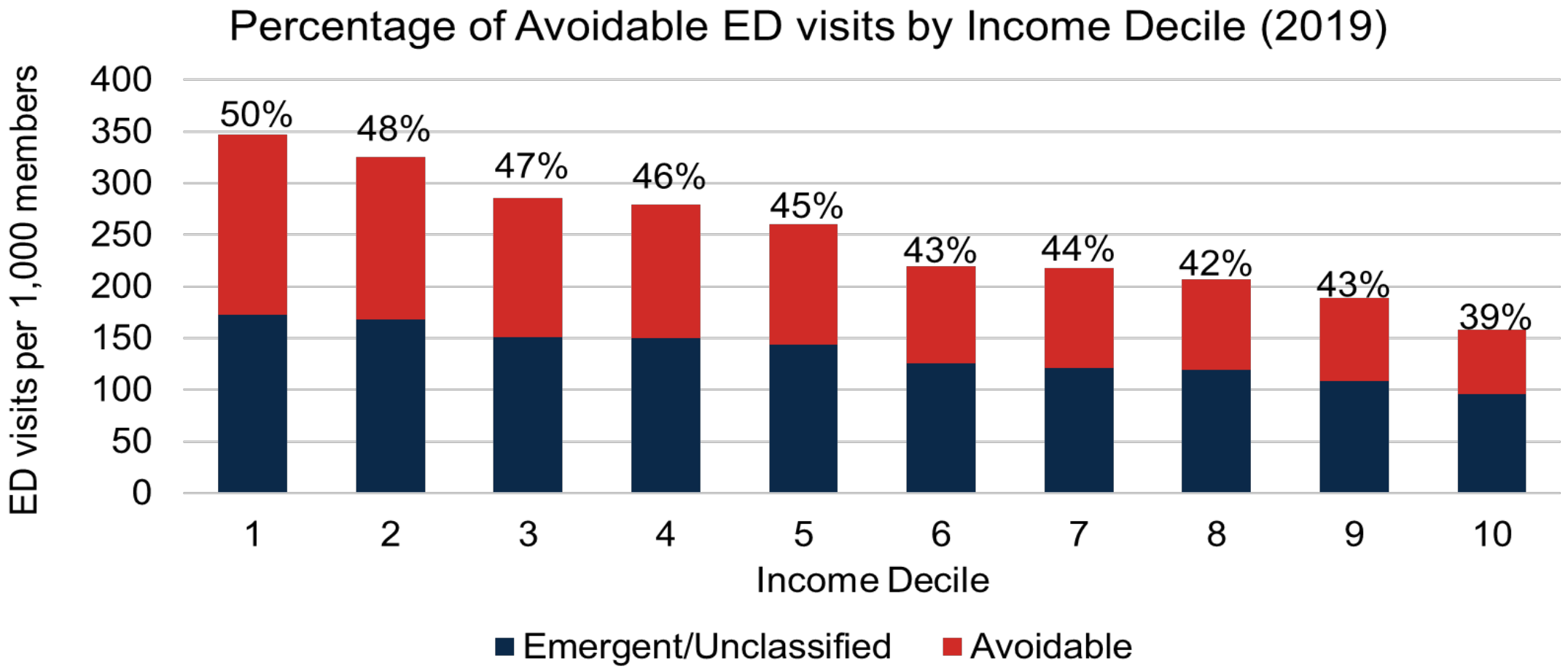
Spending per service unit drove spending growth

Service Category	2019 Volume	2019 Spending per unit	Percent change in spending per unit					4-year percent change in volume
			2016	2017	2018	2019	Total 4-year	
Inpt. acute stay	33,683	$28,015	9.5	7.3	7.0	9.3	37.4	-10.2
Outpatient claim	1,011,124	$1,544	6.2	4.8	8.5	8.3	30.7	-2.4
Professional claim	8,270,885	$218	1.6	2.3	0.9	1.9	6.8	2.1
ED visit*	179,072	$1,904	10.0	7.9	9.1	11.4	44.3	-10.3

- Changes in spending per unit may be affected by changes in service mix and in service-level prices
- Categories of services derived from the CT APCD Data Dictionary claim type detail.
- Includes CT residents under age 65. Results are not age/gender adjusted.
- Inpatient stay units defined as discharges, which can include multiple claims. "Other" category of service units defined as individual claims.

*ED includes both professional and outpatient ED claims if delivered in an ED.

A higher number and percentage of ED visits are avoidable for residents of lower income communities



What else are the states doing?

- **Massachusetts**
  - Recently proposed several policy changes after exceeding its cost growth target in 2018 and 2019. Legislation is likely to be introduced in 2022. Some of the proposed changes include:
    - Strengthen accountability for excessive spending above the target
    - Introduce price caps and limit facility fees
    - Adopt default out-of-network payment rates
    - Enhance scrutiny and oversight of capacity expansions including in ambulatory care
    - Set targets for consumer out-of-pocket spending growth and for health equity
    - And more!

Public Comment

Next Steps and Wrap-up

Upcoming Steering Committee Meetings

- March 29th from 9:00 – 10:30am (review of 2020 cost trend experience)
- May meeting – to be scheduled
- June 23rd from 12:00 – 1:30pm