Rhode Island Health Care Cost Trends Steering Committee

June 23, 2022

Agenda

1. Welcome
2. Approval of March Meeting Minutes
3. Setting Cost Growth Target Values for 2023 and Beyond
4. Public Comment
5. Next Steps and Wrap-up
6. Appendix – Updates
    - Sustainability
    - Value-Based Payment Compact

Welcome

Approval of Meeting Minutes

Approval of Meeting Minutes

- Project staff shared minutes from the March 29th Steering Committee meeting in advance of the meeting.
- **Does the Steering Committee wish to approve the March meeting minutes?**

Setting Cost Growth Target Values for 2023 and Beyond

Context for RI's Cost Growth Target

- Rhode Island's Cost Growth Target was established during the summer and fall of 2018. It was memorialized by a **compact** signed by the coalition of employers, provider organizations, insurers, consumer representatives, and state agencies that became this Steering Committee.
- The Cost Growth Target was supported by former Governor Raimondo's subsequent **Executive Order** in February 2019.
- This target was set at **3.2%** for four years, i.e., 2019 through 2022, to focus increased attention and activity on improving health care affordability. We now need to consider values for 2023 and beyond.

Context for RI's Cost Growth Target

- The 2019-2022 target was set to the value of Rhode Island's **Potential Gross State Product (PGSP)**, consistent with the approaches of the other two early cost growth target states, Massachusetts and Delaware.
- Subsequent states have used **other economic indicators** to inform their cost growth target values. In a short while we will review what the indicators are, and the cost growth target values they have produced. As we do so, we will be mindful of current market inflation and workforce trends.
- First, however, we will hear from **David Cutler** about inflation's impact on health care spending, implications for setting cost growth targets, and the recent discussions about target setting within the Massachusetts Health Policy Commission.

David Cutler

How does inflation affect health care?

Wages

- 50-60% of total spending.
- Wages increase to reflect higher prices.

Supplies:

- Most important is pharma, which may not be much affected by general inflation (drug price >> drug cost)
- Other supply costs would likely rise with inflation (food, cleaning)

Best guess: pass through to costs ~ 65-70% of inflation

Should targets allow for this?

YES

In an era of permanently higher inflation, it would be hard to envision prices not going up in health care

Survival of some institutions may be at risk

NO

No adjustment was made when inflation was lower

Providers can still cut in other ways.

Selective application of targets may be in order (differential by financial health)

A predictable target is best

Economic Indicators Used in Other States

State	Methodology	Cost Growth Target Values
CT	80/20 blend of forecasted median income and PGSP Add-on factors: +0.5% for CY 2021, +0.3% for CY2022, +0.0% for CY 2023-2025.	3.4% for 2021 3.2% for 2022 2.9% for 2023-2025
DE	PGSP Add-on factors: +0.25% for 2021, +0.0% for CY2022-2023	3.25% for 2021 3.0% for 2022-2023
MA	2018-2022: PGSP (3.6% in 2018) minus 0.5 2023 and beyond: default rate of PGSP*	3.1% for 2018-2022 3.6% for 2023*
NJ	75/25 blend of median projected household income and PGSP Add-on factors: +0.3% for 2023, +0.0% for 2024, -0.2% for 2025, -0.4% for CY2026-2027.	3.5% for 2023 3.2% for 2024 3.0% for 2025 2.8% for 2026 2.8% for 2027

Note: These cost growth target values, except for MA for 2023, were set before inflation reached its 2022 levels.
*The MA HPC can modify its benchmark value for 2023 and beyond to a reasonable amount, subject to legislative review.

Economic Indicators Used in Other States (cont'd)

State	Methodology	Cost Growth Target Values
NV	Changing blend of forecasted median wage and PGSP, with increasing weight on forecasted median wage over time	20/80 (3.19%) for 2022 35/65 (2.98%) for 2023 50/50 (2.78%) for 2024 65/35 (2.58%) for 2025 80/20 (2.37%) for 2026
OR	Non-formulaic consideration of: • historical GSP • historical median wage • CMS waiver & legislative growth caps applied to the state's Medicaid and publicly purchased programs	3.4% for 2021-2025 3.0% for 2026-2030
WA	70/30 blend of historical median wage and PGSP, with a downward adjustment starting in 2024	3.2% for 2022-2023 3.0% for 2024-2025 2.8% for 2026

Note: These cost growth target values were set before the COVID-19 pandemic.

Economic Indicators Used in Other States (cont'd)

- For the first five states to establish cost growth targets, states:
  - started with benchmark values that were **59-70%** of their 20-year growth (1995-2014)
  - dropped those values over time to **52-60%**

- Rhode Island was the exception, keeping the cost growth target at 3.2%. This value was equivalent to **60%** of the state's 20-year rate of health care spending growth.

Inflation

- When Cost Trend Project began, the calculation of PGSP used a forecasted inflation rate of 2.0%.
  - We used the Personal Consumption Expenditures (PCE) Price Index (PCE) as our inflation measure, as it is the input used in calculating PGSP. The PCE index is a measure of the prices that people living in the United States, or those buying on their behalf, pay for goods and services. It is known for capturing inflation (or deflation) across a wide range of consumer expenses and reflecting changes in consumer behavior.
- The 12-month inflation rate using PCE was 6.3% through April 2022.

Inflation's Impact on Health Care Spending

- Research has shown that increases in health care inflation has an upward impact on health care spending.
- The impact is not immediate, but lags.
- Why? Because when prices rise in the general economy, it does not impact health care prices right away.
  - Medicare prices for most services are updated annually based on *projected* growth in input costs. The updates for 2021 and 2022 were finalized when expected inflation was still relatively low; Medicare prices for physician services are not updated to reflect input cost changes.
  - Commercial prices are often defined within multi-year contracts.
  - Medicaid prices change infrequently and are not specifically linked to input costs.

The Relationship Between the Economy and Health Care Spending (initially presented 9-4-19)

We found three reputable analyses that look at the relationship between the economy and health care spending.

We can confidently say that the economy does indeed affect health care spending, and that there is a strong relationship between certain economic indicators and the economy, but the effect on health spending occurs over an extended period of time.

Evidence can be found in the following three reports:

1. *Assessing the Effects of the Economy on the Recent Slowdown in Health Spending* (2013) Kaiser Family Foundation and Altarum Institute
2. *Health Spending Growth: The Effects of the Great Recession* (2015) The Brookings Institution
3. *The Growth of Health Spending in the USA: 1776-2026* (2017) Thomas Getzen, Temple University

The Relationship Between the Economy and Health Care Spending (initially presented 9-4-19)

Kaiser and Altarum developed a statistical model to track how the growth in national health spending varies with macroeconomic indicators and found a strong relationship between inflation and real GDP and health care spending over an extended period of time.

- 85% of health care spending growth could be predicted using inflation and real GDP over the period 1965-2011.

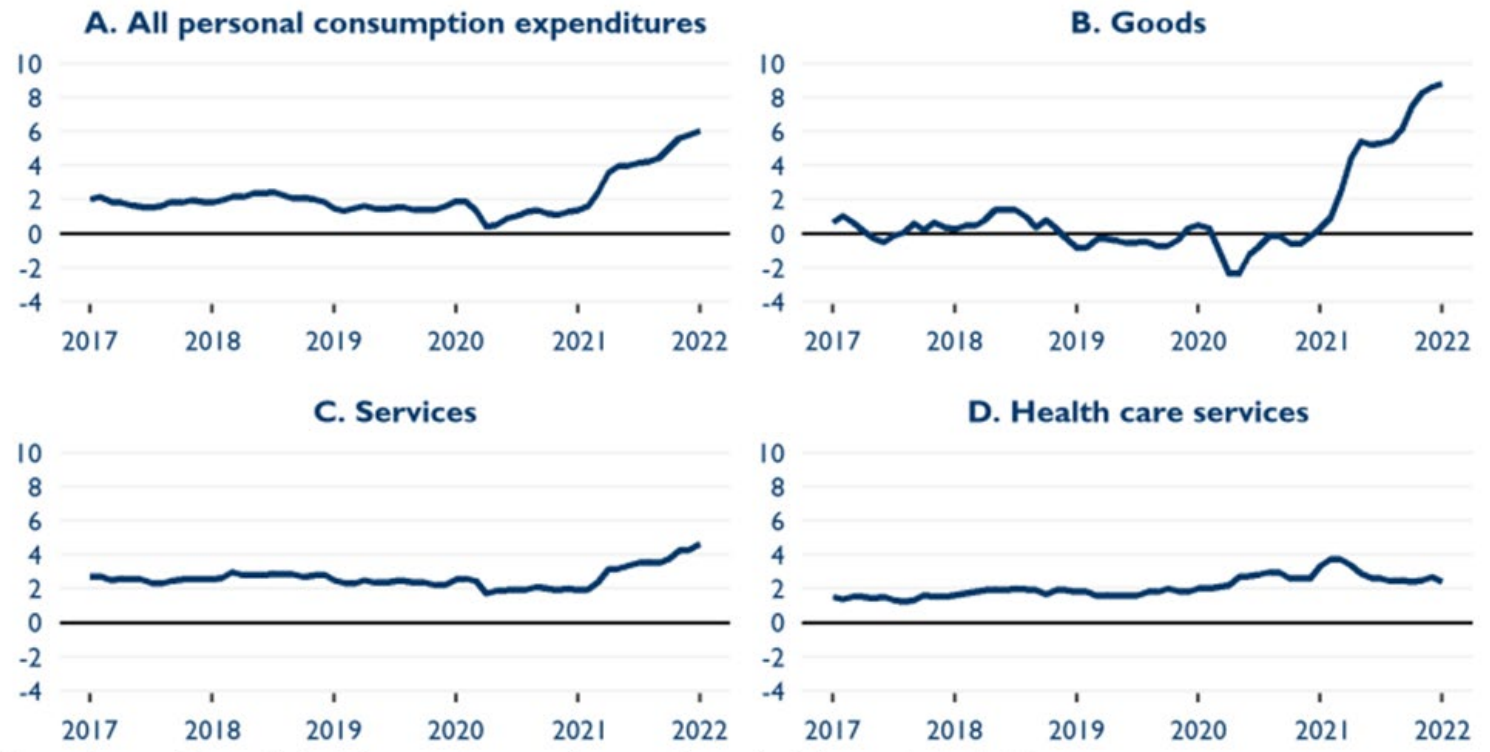
This model also showed that the effect of the macroeconomy on health care spending lags economic change:

- GDP affects health care spending over a period of six years, and inflation does so over two years.

Inflation's Recent Impact on Health Care Spending

Figure 1. Inflation by Product Type, Jan. 2017-Jan. 2022

Year-over-year percent change



Source: Bureau of Economic Analysis, personal consumption expenditure price indices; author's calculations.

USC Schaeffer

BROOKINGS

Three Straw Model Options

- The following slide describes three options for setting cost growth target values following the end of the current compact's expiration.
- None of the options represents a proposal from either OHIC or the co-chairs. Rather, the three options are intended to stimulate conversation and exploration of options so that the Steering Committee may arrive at a consensus recommendation.

Possible Options for Setting Target Values

- **Option 1:** Set five years of target values based on long-term forecasted state economic growth and/or forecasted median wage growth and contextualize short-term trend.
- **Option 2:** Set five years of target values based on long-term forecasted state economic growth and/or forecasted median wage growth with a lagged adjustment if general inflation was above the long-term forecast.
- **Option 3:** Set two years of target values that reflect the anticipated impact of inflation, and three years of values that reflect an anticipated return to lower inflation levels.

Option 1

Set five years of target values based on long-term forecasted state economic growth and/or forecasted median wage growth and contextualize short-term trend.

Pros:

- Consistent with prior method and that of all other cost growth target states
- Provides predictable targets
- Anticipates forecasted return to lower inflation rates in 2 years

Cons:

- Leaves unresolved how to apply accountability for the short term
- Inflation forecasts may be incorrect

Option 2

Set five years of target values based on long-term forecasted state economic growth and/or forecasted median wage growth with a lagged adjustment if general inflation was above the long-term forecast.

Pros:

- Creates near-term targets that reflect the impact of inflation
- Provides predictable targets
- Anticipates forecasted return to lower inflation rates in 2 years

Cons:

- Past experience with lagged inflation impact may not apply perfectly now
- May not account for health care-specific inflationary factors
- Inflation forecasts may be incorrect

Option 3

- Set two years of target values that reflect the anticipated impact of inflation, and three years of values that reflect an anticipated return to lower inflation levels.

Pros:

- Acknowledges the anticipated impact of inflation
- Provides multi-year stability for payer and provider planning purposes

Cons:

- Current forecasts for a return to much lower levels of inflation in two years may not come true
- The exact timing and impact of inflation on health care spending is uncertain

Public Comment

Next Steps and Wrap-up

Upcoming Steering Committee Meetings

- July 27th from 12:30 – 2:00pm
- September 23rd from 3:00 – 4:30pm

Appendix - Updates

Update: Sustainability

Update: Value-Based Payment Compact

Value-Based Payment Compact

- The VBP Subcommittee held its ninth and final meeting on March 30th.
- 21 members and affiliates of the Subcommittee **signed a compact** committing themselves and their organizations to the recommendations developed by the VBP Subcommittee. Those recommendations included but were not limited to adoption of three payment models:
  - hospital global budgets for facility and employed clinician professional services
  - prospective payment (capitation or episode-based payment) for high-volume and high-cost specialty care providers who are not employed by hospitals
  - prospective payment for primary care.

Value-Based Payment Compact

- Representatives from the following organizations have signed the compact:
  - Amica
  - Blue Cross Blue Shield of Rhode Island
  - Brown University
  - Care New England
  - Coastal Medical
  - CVS Health
  - Hospital Association of Rhode Island
  - Hope Health
  - Lifespan
  - Neighborhood Health Plan of Rhode Island
  - Point32Health
  - Prospect Health Services of Rhode Island
  - Rhode Island Business Group on Health
  - Rhode Island EOHHS
  - Rhode Island Foundation
  - Rhode Island Medical Society
  - Rhode Island OHIC
  - Rhode Island Parent Information Network
  - Rhode Island Public Expenditure Council
  - WellOne

Value-Based Payment Compact

- The compact includes a set of key **targets** with dates, no later by which key activities should happen. Some of these include:
  - engagement of CMMI in discussions of Medicare participation in the VBP models: 4-1-23 implementation.
  - agreement among a working group of state organizations, payers, hospitals, and other parties on key parameters of the hospital global budget model: 7-1-23
  - an independent study of hospital costs and an independent study of the question of cost-shifting: 7-1-24
  - putting in place sufficient administrative capacity within state government to oversee the successful implementation of the hospital global budget model: 7-1-25
  - implementation of the hospital global budget model: 1-1-26
- We'll discuss follow-up actions to meet these targets in a subsequent meeting.