Rhode Island Health Care Cost Trends Project
Steering Committee Meeting Minutes
EOHHS – Virks Building – 3 West Road, Cranston
September 23, 2022
3:00-4:30pm

Steering Committee Attendees:
Patrick Tigue, Office of the Health Insurance Commissioner
Michele Lederberg, Blue Cross Blue Shield Rhode Island
Al Kurose, Coastal Medical - Lifespan
Larry Wilson, The Wilson Organization
Stephanie de Abreu (on behalf of Tim Archer), UnitedHealthcare
Lisa Tomasso (on behalf of Teresa Paiva-Weed), Hospital Association of Rhode Island
Dan Moynihan (on behalf of Arthur Sampson), Lifespan
Jay Penta (on behalf of Paul Bartosic), Point32Health
Sam Salganik, Rhode Island Parent Information Network
Michael DiBiase, Rhode Island Public Expenditure Council

Unable to Attend:
Al Charbonneau, Rhode Island Business Group on Health
Tony Clapsis, CVS Health
Diana Franchitto, Hope Health
Peter Hollmann, Rhode Island Medical Society
James Loring, Amica Mutual Insurance Company
Betty Rambur, University of Rhode Island College of Nursing
Neil Steinberg, Rhode Island Foundation
Larry Warner, United Way of Rhode Island

I. Welcome

- Michele Lederberg welcomed Steering Committee members to the September meeting and reviewed the agenda.

II. Approve meeting minutes

- Al Kurose asked if Steering Committee members had any comments on the July 27th meeting minutes. The Steering Committee voted in favor of approving the July meeting minutes with no opposition or abstentions.

Patrick Tigue noted that the present conversation would be about the new cost trends compact and it was likely that the Steering Committee would need an additional meeting to reach a consensus.

III. New Cost Trends Compact for 2023-27

Michael Bailit summarized the Committee's summer conversations, highlighting that members had not yet attained consensus on 2023-27 cost growth target values. He stated that the goals of the present meeting were to continue discussing the selection of target values and to deliberate on the public health and equity measures for inclusion in the compact, the latter in response to Sam Salganik's proposal to the co-chairs.

- Michael DiBiase inquired about the rationale for Rhode Island's multi-year set of targets.
    - Michael Bailit said that the rationale was that doing so allowed payers and providers to plan for their contract negotiations. Additionally, it took lots of Steering Committee time to determine values. Finally, he noted that the other cost growth target states set multi-year targets too.

IV. Target Methodology and Values

Michael Bailit detailed the three options for consideration, naming the pros and cons of each.

Option	2023	2024	2025	2026	2027
Option 1	3.2%	3.2%	3.2%	3.2%	3.2%
Option 2	6.7%	5.2%	3.5%	3.2%	3.2%
Option 3	5.3%	4.9%	3.8%	3.5%	3.5%

- Michael DiBiase commented that one of the objectives of the cost growth target was to keep the economic situation in Rhode Island aligned with the overall economy. Therefore, he suggested accounting for how the government reacted to inflation.
- Erin Boles Welsh from Point32Health voiced her concern for potential unintended consequences for consumers if the Steering Committee pursued Options 2 or 3. She was nervous that these targets would become a 'floor' instead of a 'ceiling' as intended.
- Dan Moynihan said that his ideal option would be between Options 2 and 3. He felt Option 2 best reflected reality but liked the inclusion of household income in the rate in Option 3. However, he felt that Option 3 muted the effect of inflation too drastically.
    - Lisa Tomasso agreed with Dan but disagreed with Erin about the values becoming a 'floor', noting that in Rhode Island, hospitals are on a rate growth cap.
    - Patrick noted that the hospital rate growth cap was set as the Consumer Price Index (CPI) plus 1%, making the cap a more generous allowance than the cost growth target.
- Al Kurose referenced the NASHP hospital data, which showed systems' profit margins had a median of $0 for over a decade. He noted Option 1 would have destructive consequences for systems and supported Option 3.
- Michele Lederberg stated that while it was difficult to accept increasing the target values, the rationale was that participants needed to account for both inflation and household income. She added that having five years of targets would aid the co-chairs' conversations with the General Assembly when seeking additional funding.
    - Al Kurose agreed, adding that there was a need to look at long-term affordability when setting these targets. He noted that systems believed they were in transient crisis-level states which justified higher target values.

    - Patrick Tigue added that Rhode Island was unique in its consensus-driven process in setting the target values; in other states, the target was set via regulatory process or statute.
- Michael DiBiase asked why the target values mattered.
    - Michael Bailit replied the hope was that payers and providers would use them in the marketplace.
    - Michele Lederberg added that as with the value-based payment work, bringing down cost growth was a multi-year effort.
- Sam Salganik and Larry Wilson showed support for Option 3. Larry noted that Option 2 seemed unrealistic. He asked about the large decrease in target values from 2023 to 2024 and whether household income growth accounted for demographic variation.
    - Michael Bailit responded that the decline reflected federal projections that inflation in 2022 will by year-end be lower than in 2021. To Larry's second question, he answered that the median, not mean, value was used.
- Dan Moynihan asked if there was any merit to creating two new options: one with a 25/75 blend of PGSP and median household income and another with a 75/25 blend.
    - Michael Bailit responded that this was possible, and observed that other states vary on their blend percentages.
    - Patrick Tigue noted it was worth looking at, but conceptually, the weighting was a value judgement of which component was more significant in setting targets.
- Cory King explained that any of the proposed targets could be seen as aggressive; in a given population, utilization and price grow at about 3% while total change in spending is over 6%. He added that OHIC would name those who exceeded the targets since payers and providers committed to meeting the proposed targets.

Patrick Tigue summarized the discussion and announced that for the next meeting OHIC will create an additional option with most of the weighting on PGSP.

V. Public Health and Equity Target Proposal

Michael Bailit introduced the set of proposed public health and equity measures and introduced the question of how participants proposed payers and providers should be held accountable for their performance. Patrick added that while the original compact did not have specific equity targets, it contained language to ensure that quality was improved and not lessened. The current conversation was to expand upon that language and add rigor to that assessment.

- Michael Bailit narrated Peter Hollmann's written comments submitted in advance if the meeting, which indicated he did not agree with including *Pneumococcal vaccine for adults 18-65 with increased risk* because risk assessments required a clinical examination, nor did he agree with including *Infant mortality rate* because it was heavily influenced by social risk factors.
- Michael Bailit noted that others had suggested that the co-chairs consider a broader set of measures, such as those included in OHIC's Aligned Measure Sets. He explained that the co-chairs did not consider these originally because most publicly available data was for measures that were not stratified by race and ethnicity and for those that are stratified, the data are not publicly available.
- Sam Salganik expressed gratitude to the co-chairs for this proposal. He explained that he did not agree with focusing solely on the ratios in performance between the White, non-Hispanic and lowest performing group because doing so masked that there are

problems for all populations. He instead preferred measures for which there was opportunity for improvement across all populations.
    - Michele Lederberg agreed, noting that transparency alone created a layer of accountability.
    - Pat Flanagan, in a public comment, added that reporting would allow organizations to at least acknowledge where they are in their performance. Doing so sent two messages: 1) quality should be a part of the cost trends work, and 2) equity was crucial.
- Al Kurose noted that the data show the nation's underinvestment in social programs contributes to why states' quality outcomes have been abysmal. He acknowledged the difficulty in creating accountability for outcomes on some of the proposed measures.
- Dan Moynihan questioned the accountability mechanism for this equity measure proposal, as the unattributed population was quite large.
    - Michael Bailit replied that accountability would not work for the proposed measures based on the national data sources used for the proposed measures.
    - Patrick Tigue pointed out that the Committee could not use the same accountability structure reserved for the cost growth target.
- Michael DiBiase observed that payers and providers struggled with accountability on cost trends, so embarking on another accountability effort would be challenging.
    - Lisa Tomasso agreed, adding that perhaps the Steering Committee was not the best place for this work. She added that the Department of Health's framework has 20+ measures in it.
    - Sam Salganik replied that the difference between work in other agencies and that of this Steering Committee was that members of the latter saw the health care system as a whole while others were very siloed and focused on a particular provider-payer relationship.
- Stephanie de Abreu commented that this work resembled that of the Rhode Island Foundation.
    - Sam Salganik explained that the Foundation was not a working group. Al Kurose added that the Cost Trends Steering Committee was also more action-oriented.
- Sam Salganik commented that members may want a pathway toward organizational accountability over time; the proposed measures were only available at the state level. He proposed that childhood and adult obesity and maternal mortality could be starting proposals. However, he felt this discussion needed more time and suggested that the compact include language on a commitment to creating a suitable equity measure proposal.
- Michael Bailit noted that Peter Hollmann had shared his concern that the Steering Committee was not the appropriate group to assess these measures and instead, the OHIC Measure Alignment Work Group should be tasked with making a recommendation. Michael added that one proposal would be for the compact to include language that the Committee would recommend measures to the Steering Committee in the first half of 2023.
- In terms of accountability, Sam Salganik proposed starting at the organizational level with measures for which there is a substantial attributed population.
    - Michael Bailit added that members could start with state-level reporting for such measures in the first year.

VI. Public comment

- Patrick asked for public comment. There were no public comments.

VII. Next steps and wrap-up

- Project staff will create two additional options – one with more weighting on PGSP and the other with more weighting on median household income.
- Patrick Tigue will revise the compact to address members' concerns around the language of accountability on public health and equity measures. The co-chairs will revise their proposal with a subset of measures to start with for reporting.
- OHIC will scheduling an October meeting, during which members will continue the conversation on target values and accountability public health and equity measures.