Rhode Island Health Care Cost Trends Project
Steering Committee Meeting Minutes
EOHHS – Virks Building – 3 West Road, Cranston
February 28, 2023
2:30-4:00pm

Steering Committee Attendees:
Cory King, Office of the Health Insurance Commissioner
Michele Lederberg, Blue Cross Blue Shield Rhode Island
Al Kurose, Lifespan
Stephanie de Abreu (on behalf of Tim Archer), UnitedHealthcare
Erin Boles Welsh (on behalf of Kate Skouteris), Point32Health
Al Charbonneau, Rhode Island Business Group on Health
Michael DiBiase, Rhode Island Public Expenditure Council
Diana Franchitto, Hope Health
Peter Hollmann, Rhode Island Medical Society
Teresa Paiva Weed, Hospital Association of Rhode Island
Sam Salganik, Rhode Island Parent Information Network
Michael Wagner, Care New England
Larry Warner, United Way

Unable to Attend:
Tony Clapsis, CVS Health
James Loring, Amica Mutual Insurance Company
Arthur Sampson, Lifespan
Betty Rambur, University of Rhode Island College of Nursing
Neil Steinberg, Rhode Island Foundation
Larry Wilson, The Wilson Organization

I. Welcome
Michele Lederberg welcomed Steering Committee members to the February meeting and reviewed the agenda.

II. Approve Meeting Minutes
Al Kurose asked if Steering Committee members had any comments on the November 28th meeting minutes. The Steering Committee voted in favor of approving the November meeting minutes with no opposition or abstentions.

III. Informational Updates
Update #1: OHIC Leadership Transition
Cory King acknowledged Patrick Tigue's departure and noted that he was currently Rhode

Island's Acting Health Insurance Commissioner. As such, he was serving as a co-chair for the Steering Committee.

Update #2: Signing of New Cost Trends Compact
Cory reminded members that the 2023-27 Cost Trends Compact was distributed for signatures at the end of 2022. He noted that fifteen organizations were currently represented in the signatures and identified three organizations – the Rhode Island Business Group on Health (RIGBH), the Hospital Association of Rhode Island (HARI), and UnitedHealthcare (UHC) – that had not yet signed. He asked representatives from each organization if they wished to comment.

- Al Charbonneau (RIBGH) responded that members of the RIBGH Board were concerned about the impact that 6.0% cost growth in 2023 would have on consumers. He explained that even though median household income was included in the calculation of these target values, the metric seemed misleading to those who did not investigate the calculation further. He concluded that RIBGH would sign the Compact in favor of the process by which it was formed, but not in support of the cost growth target values.
- Cory voiced his support for RIBGH's viewpoint on supporting the process.
- Stephanie de Abreu explained that UHC, being a national organization, was concerned about the precedent set with agreeing to a 6% target in a single state. She concluded that UHC remained supportive of OHIC's Affordability Standards and would continue to deliberate on whether to sign the Compact.
- Teresa Paiva Weed stated that HARI would sign the Compact. She highlighted, however, that hospitals continued to feel economic and labor pressures, and cited that the lower reimbursement rates in Rhode Island (compared to those of Massachusetts and Connecticut) contributed to hospitals' struggles in maintaining a workforce. She added that these pressures could contribute to the state exceeding the target in the outer years (i.e., 2026 and 2027).
    - Cory reminded members that OHIC employed a consensus-driven process to arrive at these target values.
    - Al Kurose agreed that it was important to contextualize the comparison of cost growth trends across states with the respective base rates of payment.
    - Michael Wagner commented that coming from Massachusetts, he applauded Rhode Island's process for setting the target. He added to Teresa's comment that providers in Massachusetts have a competitive advantage due to the different reimbursement structure and environment. He indicated that Massachusetts has a newer age of plant than does Rhode Island.
    - Al Kurose said that age of plant was a compelling issue for the Steering Committee to discuss and that it would be worthwhile to think about how to resource this conversation with data.
    - Cory responded that the Steering Committee could revisit this conversation and the question of how to obtain these data at a later date.

Update #3: 2021 Cost Growth Target Performance Analysis
Jessica Mar explained that the public reporting of the 2020-21 cost growth target performance results at the state, market, payer, and ACO/AE levels would occur at a May 8th public forum. She added that new to this year's reporting was the assessment of performance for the seven

Core Measures in OHIC's ACO Aligned Measure Set, adding that these results would be reported at the market, insurer, and ACO/AE levels alongside the cost growth target results.

- Teresa Paiva-Weed commented that the assessment of quality measures did not make sense for hospitals because they did not use these screening and preventive measures. She added that the Steering Committee was not the correct forum to evaluate quality measures.
- Al Kurose clarified that ACOs, not individual hospitals, were assessed with these measures.
- Sam Salganik stated that in communicating the results of this quality analysis, project staff should be attentive to the distinction between that reporting and the other stream of work regarding the public health and health equity improvement goals.

Update #4: All-Payer Claims Database (APCD) Cost Driver Analysis

Jessica Mar shared the Data Analysis Work Group conducted a comprehensive review of all cost growth driver analyses performed for the Cost Trends project over the past three years. Having done so, the Work Group made three recommendations for areas in which the Steering Committee should develop cost growth mitigation strategies: 1) pharmacy, 2) specialty physician utilization, and 3) outpatient behavioral health (but only if high utilization and spending was viewed as problematic).

- Sam Salganik commented that Rhode Island's analyses lacked a sufficient deep dive into the issue of utilization vs. unit price for areas other than pharmacy.
    - Michael Bailit clarified that the state's analytics vendor over the past several months had developed internal-facing dashboards that showed utilization vs. unit price. He added that Rhode Island's specialty utilization seemed to be higher than in other states.
- Teresa noted that hospitals would not support pharmacy cost mitigation strategies because of the effects on their pricing of drugs they purchase at a discount through the 340B program.
- Michael Wagner agreed that it would be worthwhile to examine specialty physician utilization. With respect to behavioral health utilization, he felt that high utilization should not be assessed as a cost problem. Instead, it would be worthwhile to examine ED visits per 1,000. Members indicated agreement with Dr. Wagner's suggestion.
    - Beth Lange (as a public comment) added that she was concerned about caring for her patients due to the end of interstate telehealth once the public health emergency ended.

Update #5: Value-based Payment Compact Implementation

Cory identified two targets in the Value-based Compact that deserved reassessment.[1] He asked if the Steering Committee was still interested in pursuing the work on either target, noting that

[1] #5: "EOHHS and OHIC will determine how best to (a) perform oversight of risk exposure for certain ACOs/AEs and providers assuming significant downside risk, (b) provide technical assistance to providers entering new advanced VBP arrangements, and (c) obtain funding for the evaluation of new model implementation from the outset of compact implementation, using currently submitted data when possible, by January 1, 2023."
#6: "A working group of employers, insurers, and provider organizations will develop a detailed plan on how to increase PCP selection by patients by January 1, 2023."

for #5, the function of performing oversight of risk exposure of ACO/AEs was transitioned to EOHHS, and that the subjects of technical assistance and funding (parts b and c) were premature.

- Regarding #5, Sam Salganik suggested that under the Affordability Standards, OHIC could define requirements regarding substantial downside risk.
    - Cory responded that the challenge from when this was last pursued (2019) was the need for contract-level data from the providers. He suggested revisiting this topic at a future meeting.
- Al Kurose noted that #6 was still worth pursuing, recognizing that it would be challenging to implement in Rhode Island given its Preferred Provider Organization (PPO)-market.
    - Cory agreed to revisit this at a future meeting.

IV. Priorities for 2023

Michael Bailit explained the co-chairs' rationale for recommending the following Steering Committee priorities for 2023: 1) continue work to develop a hospital global budget model, 2) develop a pharmacy cost mitigation strategy, and 3) as stated in the VBP Compact, create an "aligned advanced VBP model for one high-volume medical specialty. He then asked for member's reactions to this proposal.

- Peter Hollmann agreed that a pharmacy cost mitigation strategy was worth pursuing. He explained that he was hesitant to pursue priority #3 because based on his prior research, he was unsure if the amount of effort would be worth the minimal gain.
- Sam Salganik raised the need to examine both pharmacy prices and consumers' out-of-pocket pharmacy spending together.
- Teresa Paiva Weed noted she would continue to be an advocate for hospital's benefiting from the 340B program, explaining that the programs provided medications that hospitals would not otherwise have.
- Michael DiBiase observed that the original Cost Trends Compact stated that the Steering Committee would measure costs against the target and would then take steps to address those costs. He wondered if these were the best areas to tackle given that context.
    - Al Kurose responded that increasing pharmacy costs continued to account for a significant part of the year-over-year trend in costs and that there was a sound logic in pursuing it.
- Peter Hollmann added that of the three listed priorities, working on hospital global budgets was the only one that would fundamentally change and impact health care costs. He added that it would be terrible if people lost access to primary care services.
- Cory asked the Steering Committee for additional input on primary care in the context of setting priorities for the year.
    - Teresa Paiva Weed responded that specialist payment reform should be part of the conversation, given the Data Analysis Work Group cited excess utilization as an issue.
    - Peter Hollmann agreed that there was a need to involve specialists in the total cost of care picture, but selecting one specialty to address in a meaningful way required a lot of work.
    - Michael DiBiase noted that he had heard anecdotally that people did not have trouble accessing specialty providers in the state, but the issue was that the

primary care system did not mediate that utilization. It was difficult to prevent people from going straight to their specialist.
    - Mark Jacobs (as a public comment) noted that even if people managed to have a primary care appointment, those physicians spent the time triaging the patient. He asked whether there were available data on the costs specialists generated when treating a referred patient.
    - Al Kurose shared that Coastal had those data, but was unsure how they were socialized to providers. He added that Chris Koller years prior had shared data that increased density of PCPs correlated with lower health care costs, which highlighted that primary care could be the best way to control the trajectory of health care costs.
    - Mark Jacobs (as a public comment) added that primary care capitation without capitation for specialists made it very difficult for PCPs.
    - Michael Wagner emphasized the need to create advanced primary care teams, which involved integrating many services and moving away from the fee-for-service system.
- Michele Lederberg encouraged the Steering Committee to select priorities that were manageable and actionable. She stated that it was sensible to select priorities that would elevate the group's shorter and longer-term goals to address cost growth in the state.
- Al Kurose commented that it would be worth the Steering Committee's time to come up with short-term interventions for primary care.

Cory summarized that the co-chairs would keep a) "primary care strategy" on the list of priorities, and b) retain an item around specialist value-based payment. He highlighted the need to communicate these issues clearly to the General Assembly. He concluded that the co-chairs would discuss takeaways from the meeting and formulate actionable next steps.

V. Public Health and Equity Target Goals Development

Due to time constraints, the Steering Committee was unable to discuss the forum in which to develop public health and equity target goals. Cory noted that this would be the first agenda topic for the March Steering Committee meeting.

VI. Public Comment

Michele Lederberg asked for public comment, recognizing the members of the public who had already participated in the conversation. There were no additional public comments.

VII. Next Steps and Wrap-Up

- Cory noted that the public health and equity target goals development discussion topic would be the first agenda topic for the March Steering Committee meeting.
- At a future meeting, the Steering Committee will revisit: a) Targets #5 and #6 from the VBP Compact, and b) data regarding the age of plant of Rhode Island hospitals.
- The next Steering Committee meeting will be on March 30th.