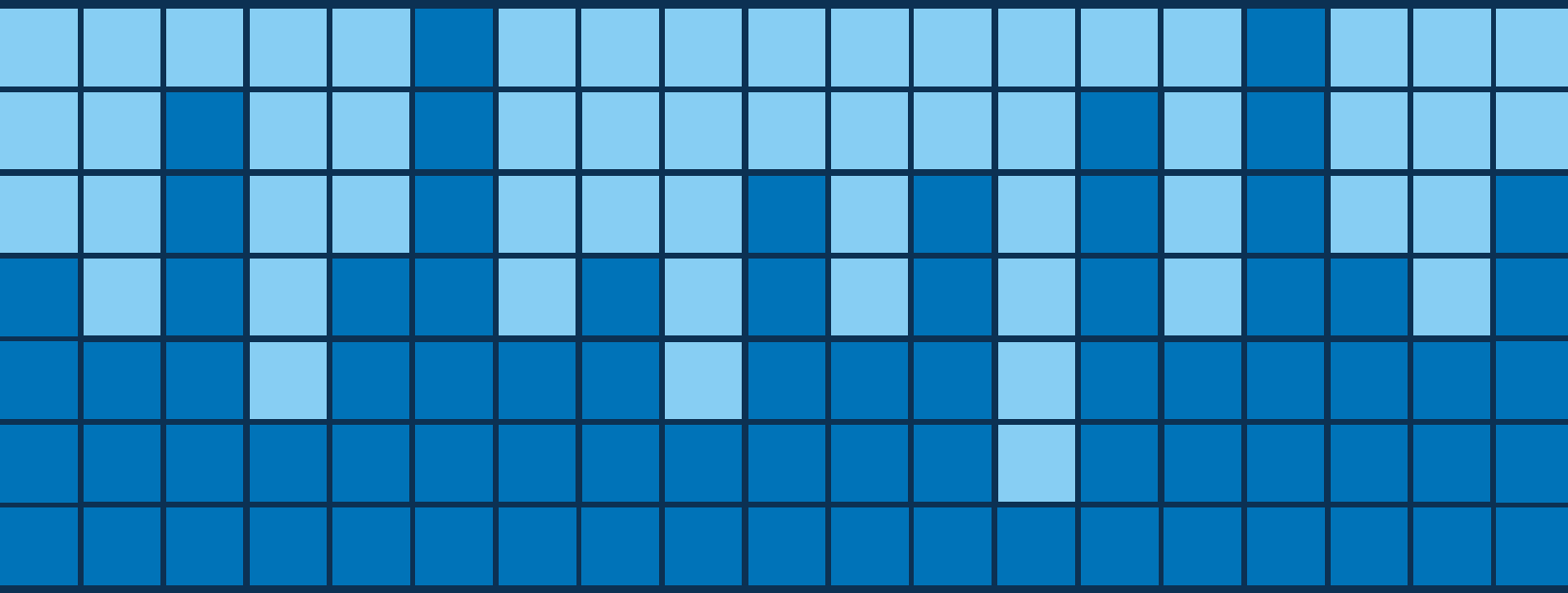
ANNUAL REPORT

Health Care Spending and Quality in Rhode Island

2023



STATE OF RHODE ISLAND
Office of The Health Insurance Commissioner
Department of Business Regulation

Index of Acronyms

ACO	Accountable Care Organization
AE	Accountable Entity
AHRQ	Agency for Healthcare Research and Quality
APCD	All-Payer Claims Database
BCBSRI	Blue Cross Blue Shield of Rhode Island
BVCHC	Blackstone Valley Community Health Care
CMS	Centers for Medicare & Medicaid Services
COVID-19	Coronavirus Disease of 2019
EOHHS	Executive Office of Health and Human Services
GDP	Gross Domestic Product
HEDIS	Healthcare Effectiveness Data and Information Set
ICER	Institute for Clinical and Economic Review
IHP	Integrated Healthcare Partners
MEPS-IC	Medical Expenditure Panel Survey Insurance Component
MMP	Medicare-Medicaid Plan
MY	Measurement Year
NA	Not Applicable
NCPHI	Net Cost of Private Health Insurance
NHPRI	Neighborhood Health Plan of Rhode Island
NR	Not Reported
OHIC	Office of the Health Insurance Commissioner
PCHC	Providence Community Health Centers
PCTL	Percentile
PGSP	Potential Gross State Product
PMPM	Per Member Per Month
PMPY	Per Member Per Year
PQIP	PCP (Primary Care Physician) Quality Incentive Program
RI	Rhode Island
THCE	Total Health Care Expenditures
THP	Tufts Health Plan
THPP	Tufts Health Public Plans
TME	Total Medical Expense
UHC	UnitedHealthcare
UHCCP	UnitedHealthcare Community Plan

Annual Report: Health Care Spending and Quality in Rhode Island (2023)

The Rhode Island Office of the Health Insurance Commissioner (OHIC) was established through legislation in 2004 to broaden the accountability of health insurers operating in Rhode Island. The Office is dedicated to: protecting consumers, encouraging fair treatment of medical service providers, ensuring solvency of health insurers, and improving the health care system's quality, accessibility, and affordability.

Contents

CHAPTER 1

Introduction

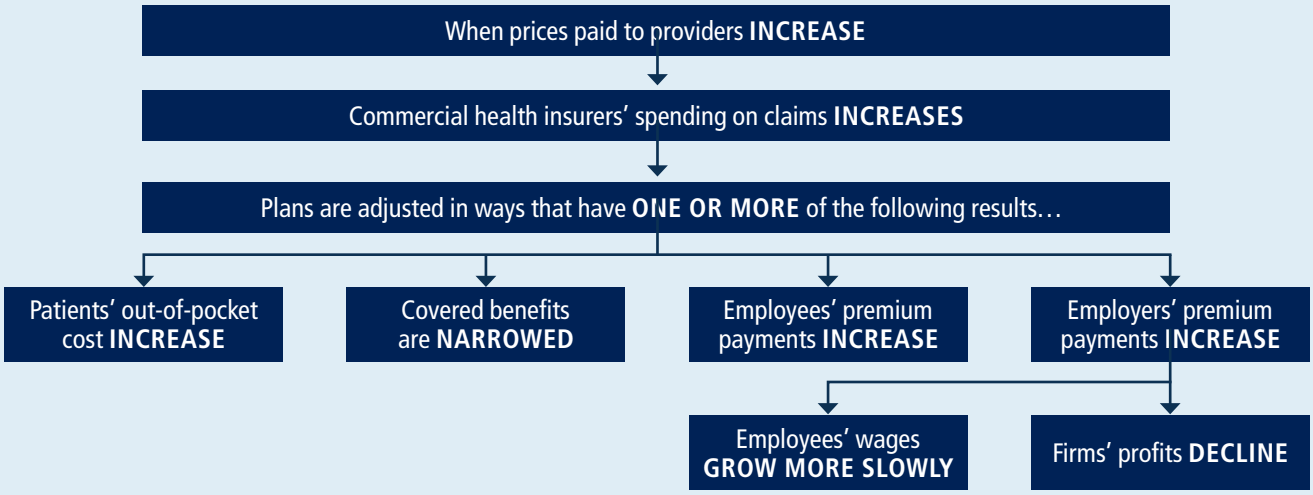
Over the last two decades, per person spending on health care in Rhode Island has grown faster than the state economy and personal income, consuming a significant and increasing proportion of household income, business revenue, and state and municipal budgets. Since 2000, per capita health care spending in Rhode Island has increased at an average annual rate of 4.6 percent,[1] compared to an average annual growth of 2.9 percent in state gross domestic product (GDP)[2] and 3.5 percent in personal income.[3] Today, per person spending on health care is 2.45 times higher than it was in 2000.

High and rising health care spending has led to dramatic increases in premiums for employer-sponsored insurance, putting a significant strain on employers and their workers. Employer-sponsored insurance is the predominant form of insurance coverage in the state, with half of Rhode Islanders obtaining coverage through an employer in 2021.[4] From 2001 to 2021, the average employer-sponsored family premium in Rhode Island grew nearly three times, from $8,023 to $22,381 per year.[5] Whether the employer funds employee health care expenses directly on a self-insured basis (as is common among large companies and municipal and state employee health benefit plans) or purchases a fully insured group plan from a commercial health insurer, these premium increases are having a significant impact on employers' costs and profitability.

High and rising health care spending has led to dramatic increases in premiums for employer-sponsored insurance, putting a significant strain on employers and their workers.

Employers have responded to increased health care costs in various ways, such as by increasing employees' premium contributions, increasing cost-sharing, reducing employment, or limiting wage growth (see Exhibit 1.1).[6,7] Data show that in Rhode

Exhibit 1.1: Effects of Higher Prices on Health Insurance Premiums and Benefits, Out-of-Pocket Costs, and Wages



Source: Congressional Budget Office, *The Prices That Commercial Health Insurers and Medicare Pay for Hospitals' and Physicians' Services*, January 20, 2022, https://www.cbo.gov/publication/57422.

1 KFF State Health Facts, *Health Expenditures per Capita by State of Residence*, accessed March 29, 2023, https://www.kff.org/other/state-indicator/health-spending-per-capita/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.
2 United States (US) Bureau of Economic Analysis (BEA), *Gross Domestic Product: All Industry Total in Rhode Island*, retrieved from Federal Reserve Economic Data (FRED), Federal Reserve Bank of St. Louis, accessed March 27, 2023, https://fred.stlouisfed.org/series/RINGSP.
3 US BEA, *Per Capita Personal Income in Rhode Island*, retrieved from FRED, Federal Reserve Bank of St. Louis, accessed March 27, 2023, https://fred.stlouisfed.org/series/RIPCPI.
4 KFF State Health Facts, *Health Insurance Coverage of the Total Population*, accessed March 29, 2023, https://www.kff.org/other/state-indicator/total-population/.
5 Agency for Healthcare Research and Quality (AHRQ), *Average Total Family Premium (in Dollars) per Enrolled Employee at Private-sector Establishments that Offer Health Insurance by Total, Rhode Island, 1996 to 2021*, Medical Expenditure Panel Survey Insurance Component (MEPS-IC), accessed March 27, 2023, https://datatools.ahrq.gov/meps-ic?type=tab&tab=mepsich3ps.
6 Laurel Lucia and Ken Jacobs, *Increases in Health Care Costs are Coming Out of Workers' Pockets One Way or Another: The Tradeoff Between Employer Premium Contributions and Wages*, UC Berkley Labor Center Blog, January 29, 2020, https://laborcenter.berkeley.edu/employer-premium-contributions-and-wages/.
7 Daniel Arnold and Christopher M. Whaley. , RAND Corporation, 2020, https://www.rand.org/pubs/working_papers/WRA621-2.html.

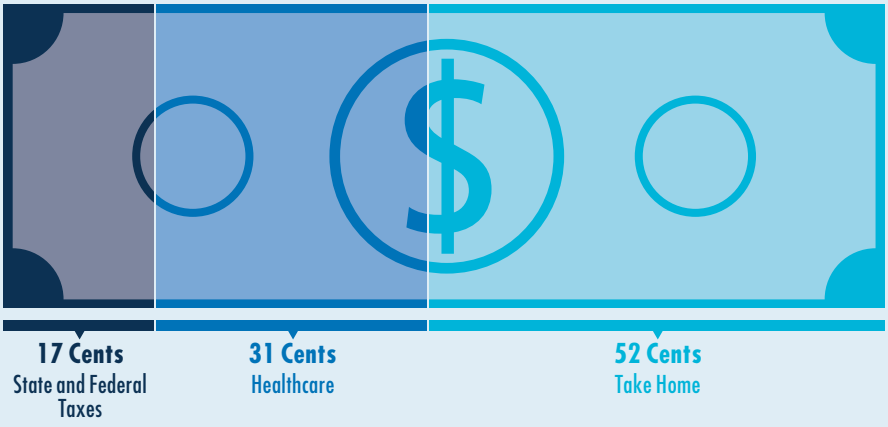
Island, employers have shifted a greater proportion of the costs of employer-based health care to employees in the form of higher premium contributions and cost-sharing. In 2001, Rhode Island workers' average premium contribution for family coverage was $1,703, or 21 percent of the entire premium. This has since increased to $6,216, or 28 percent of the entire premium, in 2021.[8] In addition, the percent of employees enrolled in a health insurance plan that has a deductible increased from 31.8% in 2003 to 94.6% in 2021. Over this same period the average annual deductible for a family plan quadrupled from $885 to $3,662.[9]

As employers turn towards plans with large deductibles and higher cost-sharing to manage the cost of providing health care to their workers, underinsurance – where individuals who have medical coverage are still exposed to financial risk – is becoming increasingly common. A survey of Rhode Islanders' insurance status, experience getting care, and use of medical services showed that 28.1 percent of Rhode Islanders were underinsured in 2022.[10] On average, Rhode Islanders spend more than $2,500 a year out-of-pocket on health care, with some spending much more to obtain care because they have coverage that requires far greater cost-sharing and/or they have significant health care needs.[11]

As a result of rising premiums and cost sharing, an estimated 31 cents of every additional dollar earned by Rhode Island families between 2017 and 2019 went to health care, leaving fewer resources for other daily needs such as housing, education, and savings (see Exhibit 1.2). In 2022, 14.9% of survey respondents had problems paying medical bills, with some being unable to pay for necessities like food, heat or rent, and others using up savings to pay for medical bills or incurring debt. Some even had to file for bankruptcy (see Exhibit 1.3).

As a result of rising premiums and cost sharing, an estimated 31 cents of every additional dollar earned by Rhode Island families between 2017 and 2019 went to health care, leaving fewer resources for other daily needs such as housing, education, and savings.

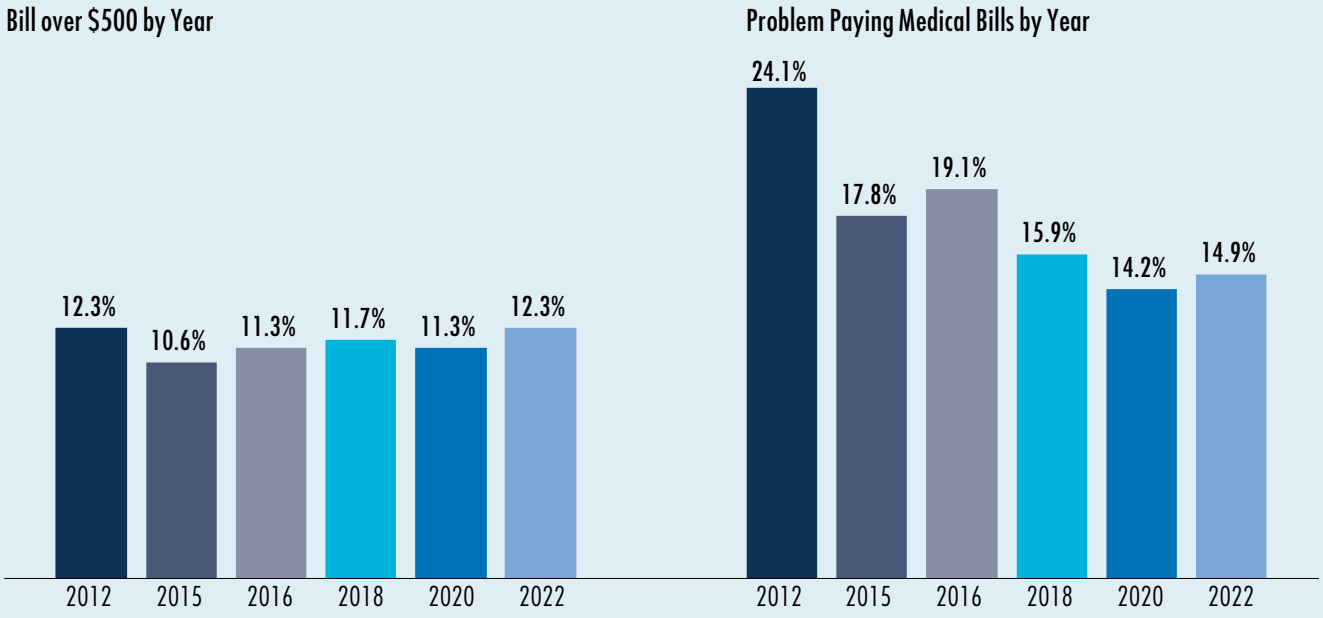
Exhibit 1.2: Allocation of the Increase in Monthly Compensation Between 2017 and 2019 for a Median Income Rhode Island Family with Health Insurance Through an Employer

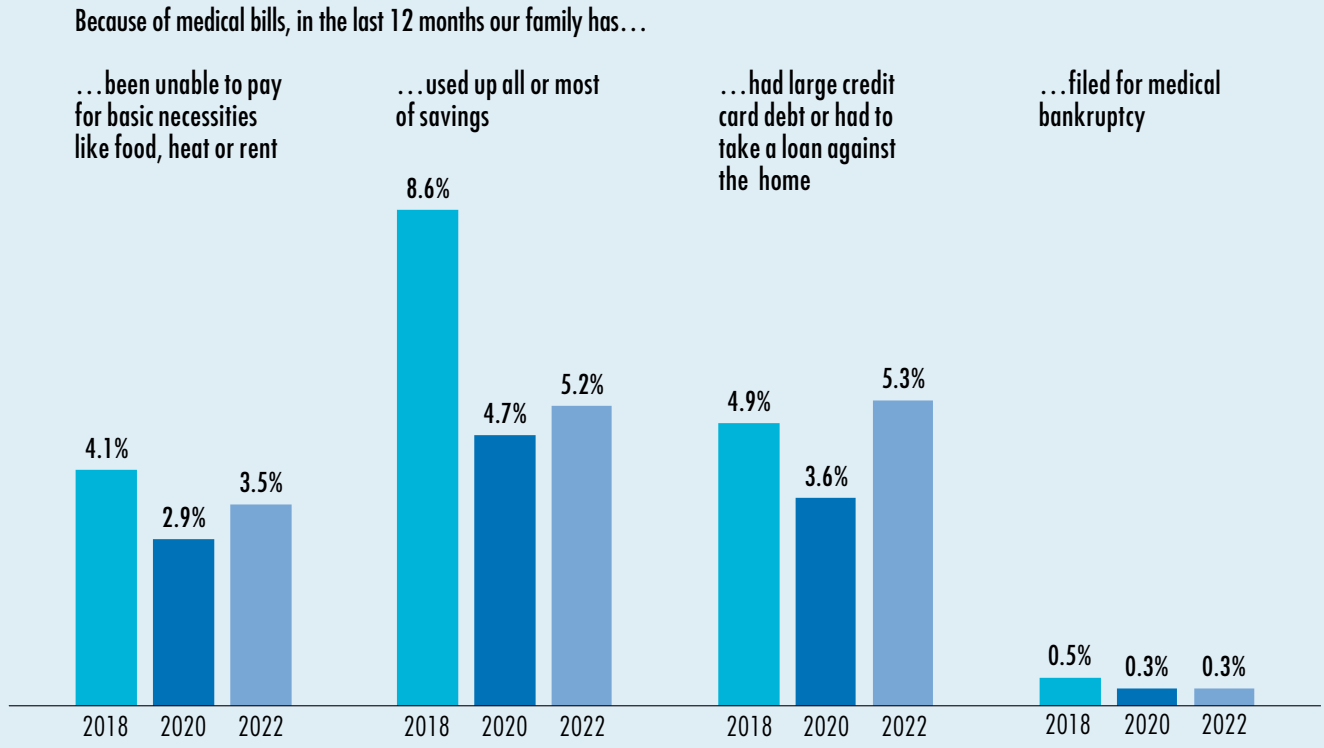


Source: OHIC analysis of AHRQ's MEPS-IC, the American Community Survey 1-year files, and the Current Population Survey. Data represent Rhode Island families who obtain private health insurance through an employer.

8 Office of the Health Insurance Commissioner (OHIC) analysis of MEPS-IC for Rhode Island private-sector establishments that offer health insurance.
9 AHRQ, MEPS-IC.
10 The 2022 Health Information Survey categorizes individuals as underinsured if: (1) their out-of-pocket costs over the past 12 months, excluding premiums, for families with incomes of 200% FPL or greater, was equal to at least 10% of household income; (2) their out-of-pocket costs over the past 12 months, excluding premiums, for families with incomes lowers than 200% FPL, was equal to at least 5% of household income; or (3) their deductible was at least 5% of household income. See: HealthSource RI, *2022 Rhode Island Health Insurance Survey*, accessed March 27, 2023, https://healthsourceri.com/surveys-and-reports/.
11 HealthSource RI. Results include all policy holders, not just those with private insurance.

Exhibit 1.3: Problems Paying Medical Bills and Financial Consequences for Rhode Islanders





Source: HealthSource RI, *2022 Rhode Island Health Insurance Survey*, accessed March 27, 2023, https://healthsourceri.com/surveys-and-reports.

An even more sobering picture emerges when looking at how medical bills have impacted certain racial groups. While 14.9 percent of the overall Rhode Island population had problems paying medical bills in 2022, a much higher percentage of Black or African American Rhode Islanders (23.6 percent) experienced this issue. Black or African American Rhode Island families also reported being unable to pay for necessities like food, heat or rent at higher rates (5.9 percent) than all Rhode Island families (3.5 percent).[12]

Against this backdrop, Rhode Island took on the challenge of slowing spending growth in 2018 when it became the third state to design a statewide target for health care spending growth. The target was implemented and became effective on January 1, 2019. Rhode Island engaged leaders in the state's health care industry to develop the target, demonstrating their shared commitment to providing Rhode Islanders with high-quality, affordable health care through greater cost transparency and increased accountability.

This report presents the findings from the Office of the Health Insurance Commissioner's (OHIC) activities to better understand and monitor the factors affecting health care spending growth in the state in 2021. **Chapter 2** presents 2021 state and market level performance against the cost growth target (insurer and provider performance are included in the Appendices). **Chapter 3** examines retail pharmacy spending and utilization patterns based on analysis of the state's All-Payer Claims Database (APCD). **Chapter 4** describes the Rhode Island health care system's performance on quality metrics. **Chapter 5** concludes with a call to action for health care leaders in public and private sectors to take all reasonable and necessary steps to keep annual spending growth below the target while maintaining high standards for quality and access.

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What is the Health Spending Accountability and Transparency Program?

The Rhode Island Legislature authorized OHIC to establish the Health Spending Accountability and Transparency Program in July 2022 to improve affordability and facilitate access to high-quality health care for all Rhode Islanders. The program builds on **voluntary efforts** initiated by the Rhode Island Cost Trends Steering Committee to curb health care spending growth and achieve the following goals:

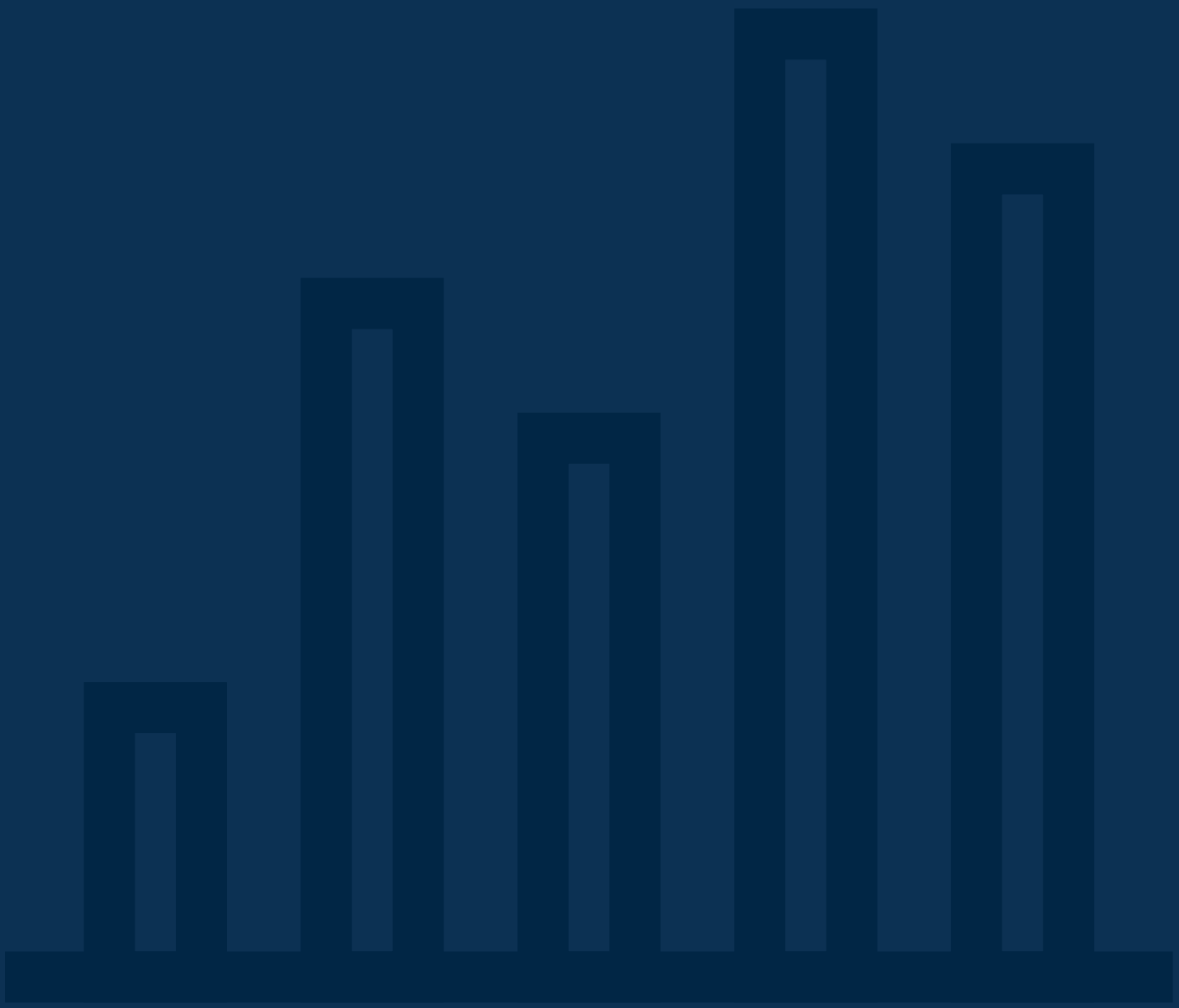
- Understand and create transparency around health care spending and the drivers of spending growth
- Create shared accountability for health care spending and spending growth among insurers, providers, and government by measuring performance against a spending growth target tied to economic indicators
- Lessen the negative impact of rising health care spending on Rhode Island residents, businesses, and government

The program seeks to achieve these goals by collecting and analyzing health care spending data to inform meaningful actions that will slow spending growth.

12 HealthSource RI.

CHAPTER 2

Trends in Health Care Spending



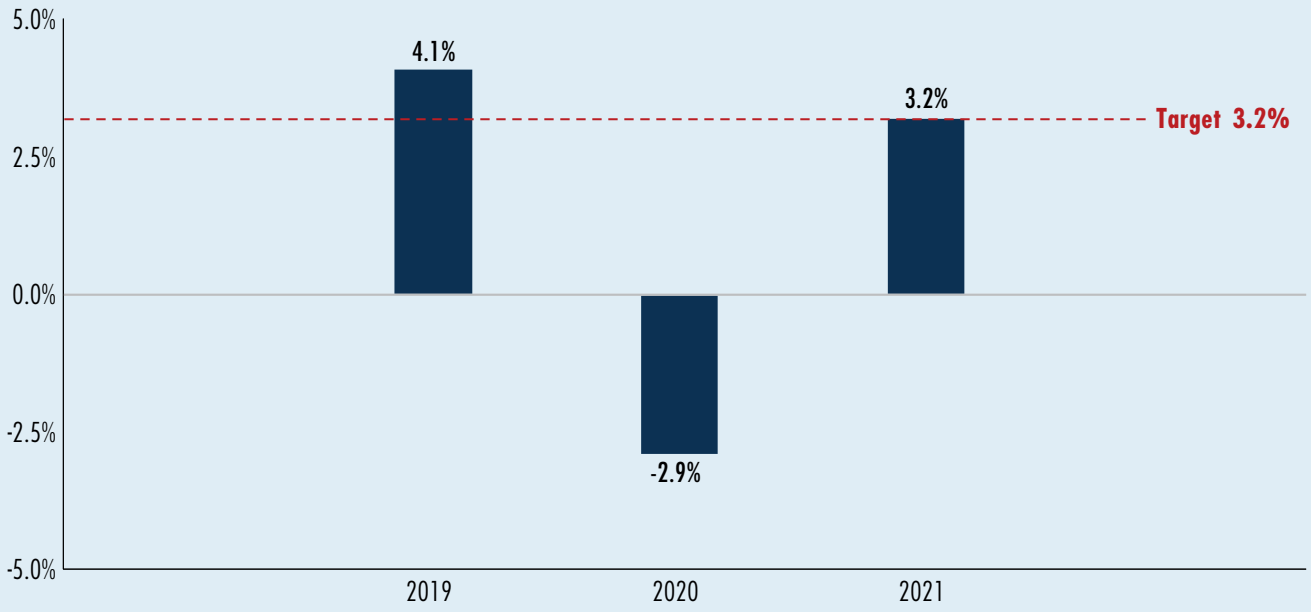
OHIC began analyzing health care spending growth in 2020 after the Rhode Island Cost Trends Steering Committee established a voluntary compact in 2018 to restrain the growth in per capita spending on health care to no more than the level of projected state economic growth. For 2019 to 2022 the state set an annual health care cost growth target of 3.2 percent, equivalent to the long-term forecasted growth in Rhode Island's Potential Gross State Product (PGSP). This chapter examines 2021 state and insurance market performance against the cost growth target. It also examines 2021 health care spending patterns based on OHIC's annual Cost Trends data collection.[1]

COVID-19 restrictions caused an abrupt reduction in the use of in-person health care, which led to a sharp drop in per capita spending in 2020. Utilization rebounded in 2021, although not to pre-pandemic levels, resulting in a 3.2 percent growth in THCE, which was equal to the target.

Statewide Spending and Spending Growth

OHIC assesses statewide health care spending growth against the cost growth target by calculating the annual change in Total Health Care Expenditures (THCE) for covered residents. THCE represents health care expenditures for Rhode Island residents who received coverage from commercial insurance (including employers that self-fund), Medicaid, and Medicare. It includes all categories of claims and non-claims payments to providers for covered services[2] delivered to insured individuals (also referred to as Total Medical Expense, or TME), and the cost of administering private health insurance (referenced as the Net Cost of Private Health Insurance, or NCPHI). OHIC measures THCE using aggregate data submitted by insurers in the state, as well as state and federal government data.

Exhibit 2.1: Statewide Performance Against the Cost Growth Target, 2019–2021



Source: OHIC analysis of TME data from insurers, the Centers for Medicare & Medicaid Services (CMS), and the Rhode Island Executive Office of Health and Human Services (EOHHS).

1 For details on the data collection and analysis methodology, see OHIC, *Rhode Island Health Care Cost Growth Target and Primary Care Spend Obligation Implementation Manual*, August 26, 2022, https://ohic.ri.gov/sites/g/files/xkgbur736/files/2022-08/RI%20Implementation%20Manual_CY%202020%20-%20CY2021_final%20v8.1.pdf.

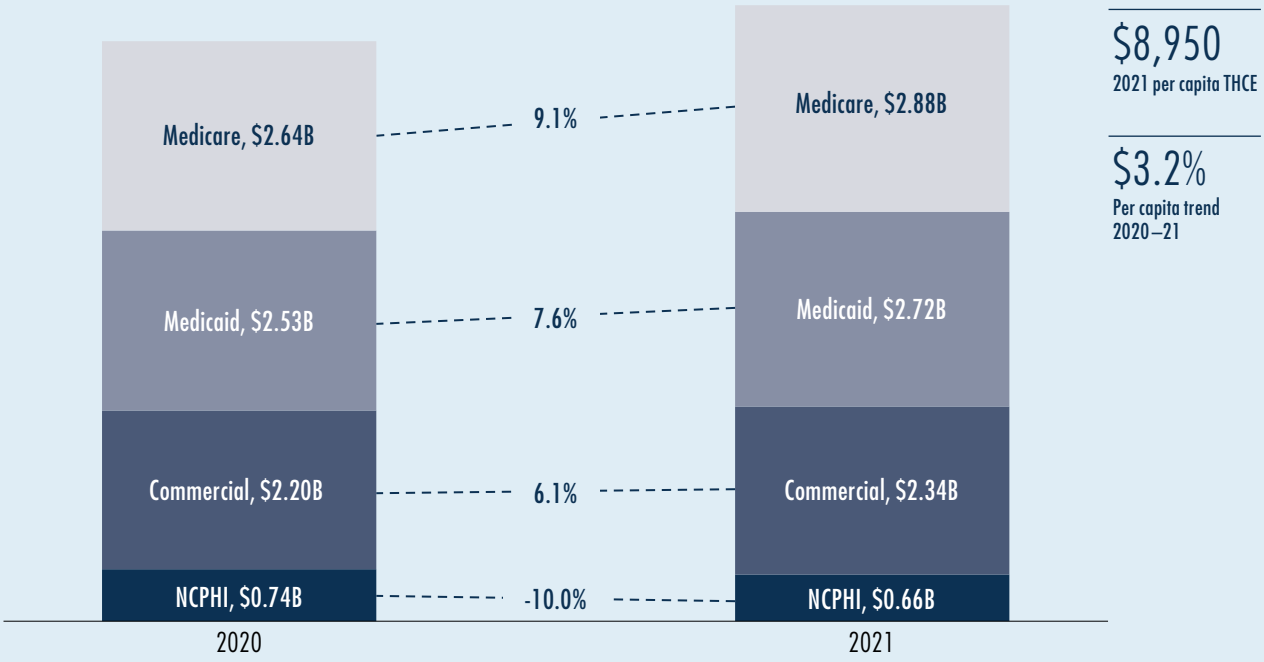
2 Some non-claims payments are not for covered services but are for incentives or infrastructure payments intended to support care delivery (e.g., electronic health record infrastructure payments and other data analytics payments).

As previously reported by OHIC, Rhode Island's per capita growth in THCE exceeded the state's target of 3.2 percent in 2019.[3] COVID-19 significantly altered health care utilization and spending in 2020. In particular, COVID-19 restrictions caused an abrupt reduction in the use of in-person health care, which led to a sharp drop in per capita spending in 2020.[4] Utilization rebounded in 2021, although not to pre-pandemic levels, resulting in a 3.2 percent growth in THCE, which was equal to the target (see Exhibit 2.1). State-level performance in 2021 was heavily influenced by a decline in Medicaid per capita spending, which may have been an artifact of federal action during the Public Health Emergency.[5]

Trends in Statewide Spending by THCE Component

Aggregate spending in the commercial market was $2.3 billion in 2021, comprising 27 percent of state THCE (see Exhibit 2.2). Combined with a commercial market enrollment decrease of 3.4 percent, this yielded a per capita spending level of $6,171, which represents a 9.7 percent increase over 2020 (see Exhibit 2.3). This increase, while far above the cost growth target, is below that of neighboring states with cost growth targets for 2021.[6]

Exhibit 2.2: Aggregate Statewide Spending Growth by THCE Component, 2020–2021



Source: OHIC analysis of TME data from insurers, CMS, the Rhode Island EOHHS, and publicly available insurer regulatory filings.

3 OHIC, *Performance Year 2020 Cost Trends Report*, April 27, 2022, https://ohic.ri.gov/policy-reform/health-spending-accountability-and-transparency-program.

4 Federal relief payments, including to Rhode Island providers, caused national health care spending to increase in 2020. Those relief payments are not available for capture in OHIC's analysis, however.

5 2021 per capita statewide spending was depressed as a result of negative Medicaid per capita trend (see Exhibit 2.3). This may be partially attributed to enrollees with extended Medicaid coverage due to the suspension of Medicaid eligibility redeterminations, some of whom obtained and utilized commercial insurance but remained enrolled in Medicaid. OHIC is unable to quantify the number of individuals affected.

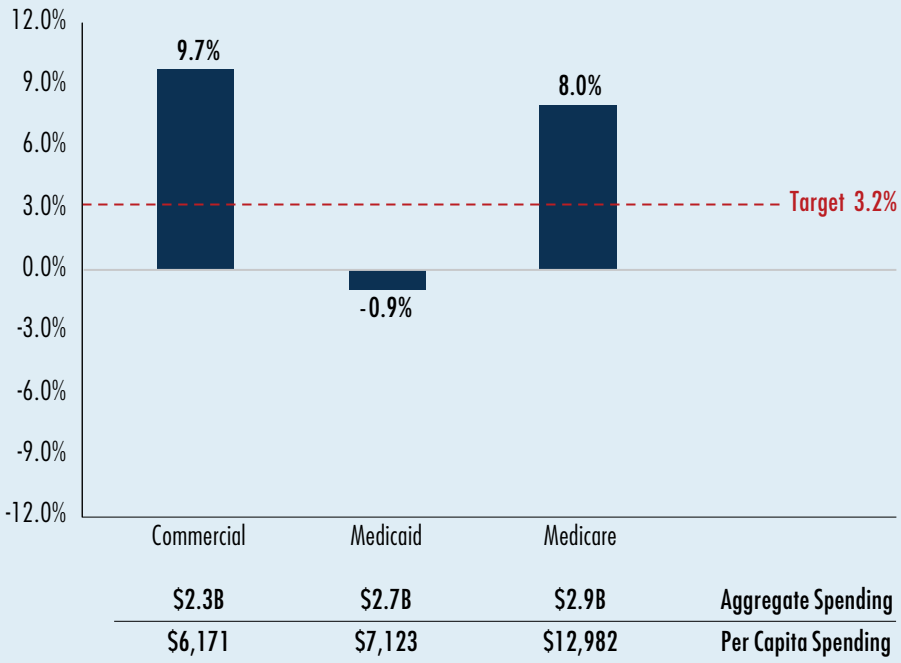
6 In 2021, Massachusetts' per capita TME for the commercial market increased by 11.6 percent. For more information, see: Massachusetts Health Policy Commission, *Hearing to Determine the 2024 Health Care Cost Growth Benchmark* (slide 6), March 15, 2023. https://www.mass.gov/doc/national-context-and-affordability-implications-of-massachusetts-trends-dr-david-auerbach/download. Connecticut's per capita TME for the commercial market increased by 18.8 percent in 2021. For more information, see: Connecticut State Office of Health Strategy, *Healthcare Cost Growth Benchmark Steering Committee Meeting*, March 27, 2023. https://portal.ct.gov/-/media/OHS/HBI-Steering-Committee/March-27-2023/Steering-Committee-meeting-3-27-23-Final-slides.pdf. Delaware reported for 2021 a per capita increase in THCE of 16.5% in the commercial market (note that at the market level Delaware only reports THCE and not TME). For more information, see: Delaware Department of Health and Social Services, *Calendar Year 2021 Results: Benchmark Trend Report* (slide 23), April 6, 2023. https://dhss.delaware.gov/dhcc/files/de_cy_2021_benchmarkreport.pdf. Oregon's per capita TME for the commercial market increased 12.1% from 2020 to 2021. For more information, see: *Oregon Health Authority, Health Care Cost Growth Trends in Oregon, 2020–2021: 2023 Sustainable Health Care Cost Growth Target Annual Report* (slide 17), May 9, 2023. https://www.oregon.gov/oha/HPA/HP/Cost%20Growth%20Target%20documents/2023-Oregon-Cost-Growth-Target-Annual-Report.pdf.

Medicare spending was to $2.9 billion in 2021, representing 34 percent of state THCE. Per capita spending on Medicare increased 8.0 percent to $12,982, while enrollment increased 1.0 percent.

Medicaid spending totaled $2.7 billion, accounting for 32 percent of state THCE in 2021. On a per capita basis, Medicaid spending decreased 0.9 percent to $7,123. Enrollment in Medicaid increased 8.7 percent, in part due to federal requirements to maintain continuous coverage during the COVID-19 public health emergency. It is likely that some of those with continuous coverage obtained private employer-based coverage prior to or during 2021 and did not incur Medicaid spending, therefore causing decline in the Medicaid growth rate.

Aggregate spending on NCPHI totaled $661.1 million in 2021. NCPHI represents the administrative costs of providing private health insurance and accounted for 8 percent of THCE in 2021. On a per capita basis, NCHPI decreased 12 percent from 2020. During the height of the pandemic in 2020, insurers saw a large increase in NCPHI due to decreased health care utilization (and therefore, decreased medical expenses). In 2021, utilization patterns returned to anticipated levels, which drove NCPHI spending down from its previously elevated levels (for more information on NCPHI, see the sidebar).

Exhibit 2.3: Aggregate TME, Per Capita TME, and Growth in Per Capita TME by Market, 2020–2021



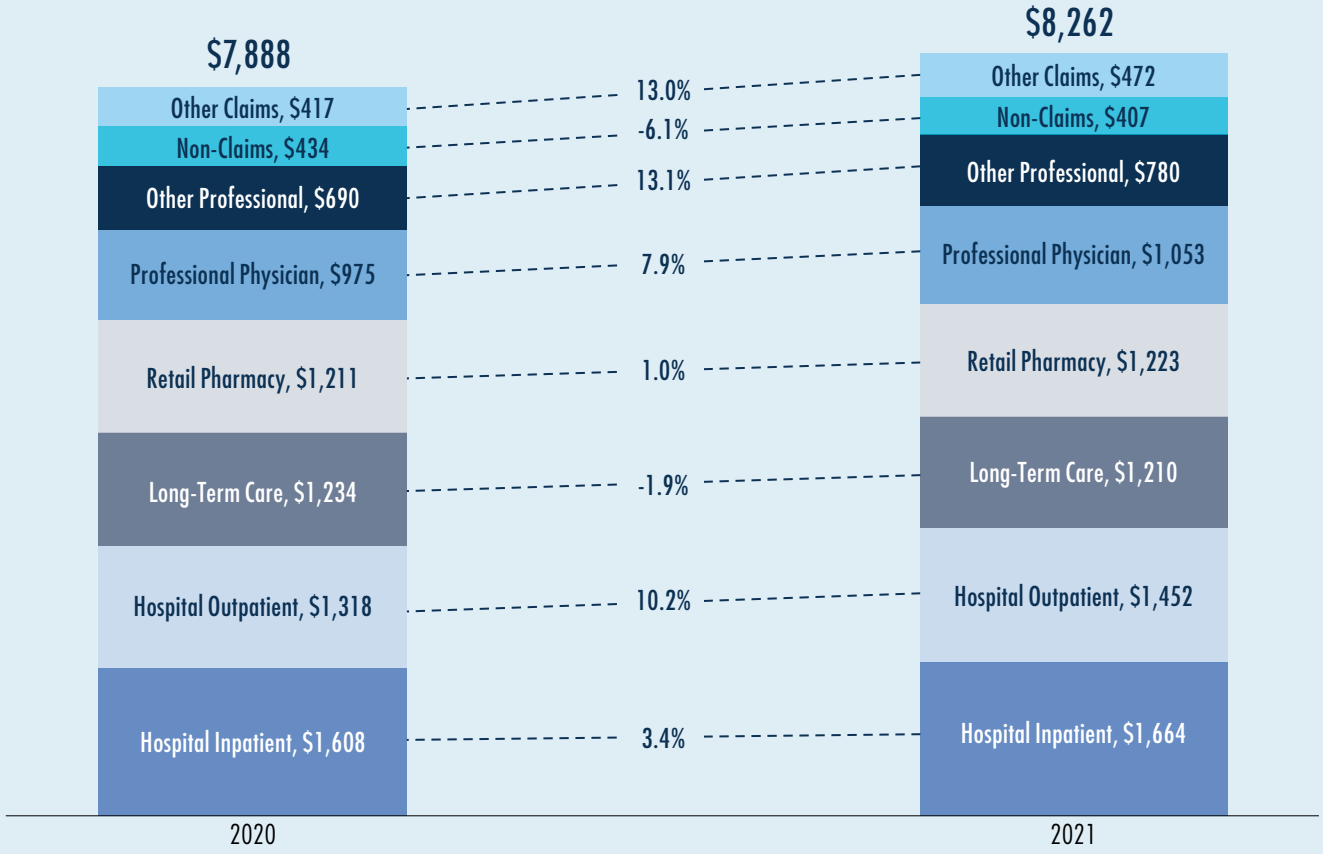
Source: OHIC analysis of TME data from insurers, CMS, and the Rhode Island EOHHS.

Understanding the Net Cost of Private Health Insurance

NCPHI captures the cost of administering private health insurance for Rhode Island residents. It is broadly defined as the difference between the premium revenue health plans receive on behalf of Rhode Island residents and the spending incurred for covered benefits for those same members. NCPHI includes insurers' costs of paying bills, advertising, sales commissions, and other administrative costs. Because plan premiums are set prospectively based on historical claims data and actuarial assumptions, NCPHI can vary significantly from year to year depending on how closely actuarial projections match actual spending on health care services.

Statewide Spending Trends by Service Category

Exhibit 2.4. Per Capita State TME by Service Category



Source: OHIC analysis of TME data from insurers, CMS, and the Rhode Island EOHHS.

A deeper look at spending by service categories shows that per capita spending on Long-Term Care and Non-Claims payments at the state level decreased in 2021, whereas spending on all other service categories increased (see Exhibit 2.4). Hospital services represent the largest portion of health care spending, with Hospital Inpatient and Outpatient services accounting for 38 percent of per capita TME. Service categories that experienced the most significant growth were Other Professional, Other Claims, Hospital Outpatient, and Professional Physician Services.

The significant increase in Hospital Outpatient and Professional Physician spending represents a rebound in utilization for those services that were delayed, avoided, or canceled in 2020 at the height of the COVID-19 pandemic. The increase in Other Professional spending, which includes behavioral health services delivered by non-physician practitioners, may have been influenced by the pandemic's profoundly negative effects on mental health. The increase in Other Claims was driven by COVID-19 testing and vaccine administration.

Per capita spending on Retail Pharmacy remained high in 2021. In contrast to previous years, however, spending growth for this service category increased only slightly. Retail Pharmacy grew by only 1.0 percent in 2021, compared to 6.9 percent in 2019 and 8.3 percent in 2020.[7] Pharmacy rebates, which totaled $420 million in 2021, had a significant impact on lowering the annual growth in Retail Pharmacy spending (see sidebar for more information on pharmacy rebates).[8] Without accounting for rebates, per capita growth in Retail Pharmacy spending was 3.9 percent.

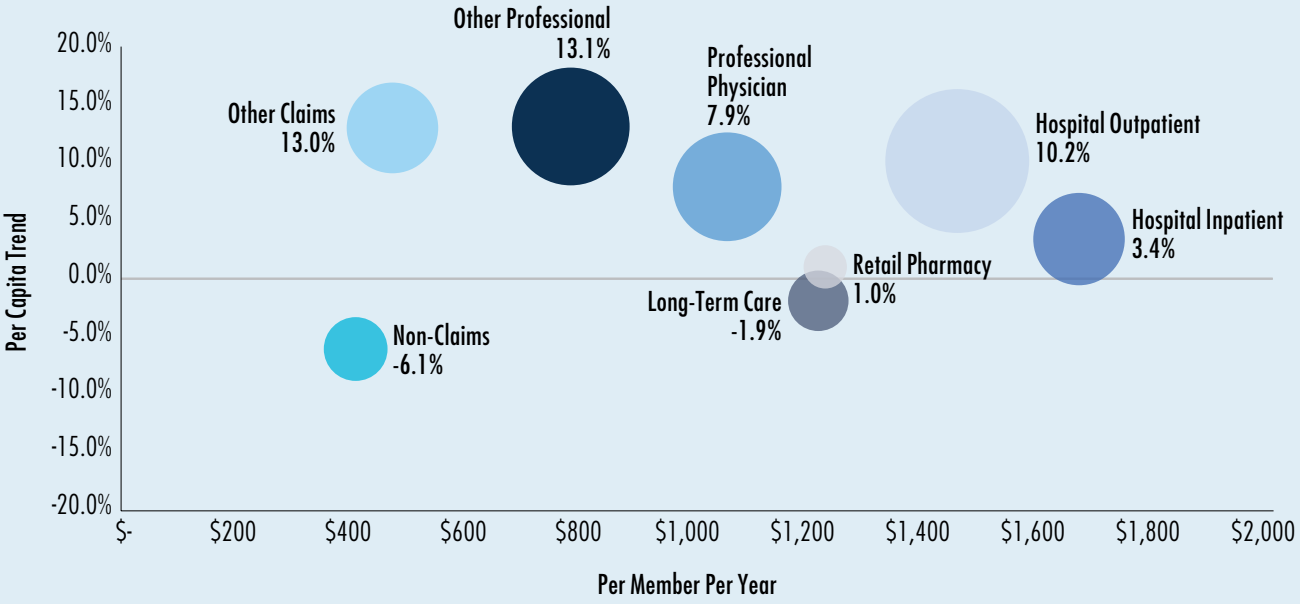
Drivers of Statewide Spending Growth

Two factors determine a particular service category's contribution to overall spending growth – the level of per capita spending for the service category, and its annual rate of growth.[9] At the state level, growth in Hospital Outpatient and Other Professional spending drove overall spending growth in 2021 (see Exhibit 2.5). Per capita spending on Hospital Outpatient services – which was already high – grew significantly in 2021, making it the largest contributor to overall spending growth. Per capita spending on Other Professional services was moderate, but increased significantly, making this service category a second significant cost driver for 2021.

Drug Rebates

Health plans often negotiate with drug manufacturers – either directly or through pharmacy benefit managers – to receive discounts on prescription drugs. These discounts or rebates are paid to the plan after a drug has been dispensed, effectively reducing the cost of the drug. Manufacturers use these rebates as a negotiation tool to earn favorable placement on the insurer's preferred drug list or formulary, which increases the drug's market share.

Exhibit 2.5: State Level Service Category Contribution to Growth, 2020–2021



Source: OHIC analysis of TME data from insurers, CMS, and the Rhode Island EOHHS.

Data are unadjusted. Retail and medical pharmacy rebates are accounted for in the reporting of Retail Pharmacy spending. Data do not include NCPHI. The width of the bubbles represents contribution to growth.

7 For more information on 2019 spending growth performance see: OHIC, *Rhode Island Cost Trends Steering Committee* (slides 9-47), April 29, 2021. https://ohic.ri.gov/sites/g/files/xkgbur736/files/documents/2021/April/Cost-Trends/steering-committee-meeting-2021-4-29-for-sharing.pdf. For more information on 2020 spending growth performance, see: Office of the Health Insurance Commissioner, *Performance Year 2020 Cost Trends Report*.

8 The timing of rebate payments may be irregular, which may cause modest distortions in the total amount of rebates in a given year.

9 Contribution to overall spending growth was calculated by taking the absolute difference in per capita spending between 2020 and 2021 for each service category and dividing it by the sum of the absolute differences in per capita spending between 2020 and 2021 for all service categories.

CHAPTER 3

Trends in Prescription Drug Spending

Prescription drug spending has been a significant driver of overall spending growth in Rhode Island and across the United States. OHIC's analysis of Cost Trends data showed that in 2021, statewide per capita spending on Retail Pharmacy amounted to $1,223, representing 15 percent of TME (see Exhibit 2.4). To further explore statewide trends in Retail Pharmacy spending, OHIC analyzed claims data from 2017 through 2021 that are available through the Rhode Island All-Payer Claims Database (APCD), HealthFacts RI. This chapter presents the results of these analyses.

Drivers of Per Capita Spending Growth on Prescription Drugs

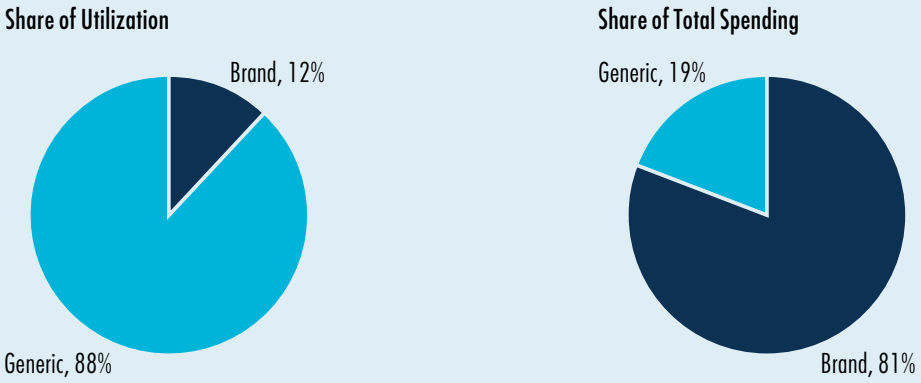
From 2017 to 2021, spending on prescription drugs for those with commercial insurance, Medicaid, and Medicare coverage in Rhode Island increased an average of 4.4 percent annually, from $120 per member per month (PMPM) to $142 PMPM. This growth was fueled by spending on brand name drugs. Between 2017 and 2021, PMPM spending on brand name drugs grew by 28 percent. By comparison, PMPM spending on generic drugs decreased 9 percent over the same time frame (see Table 3.1). In 2021, brand-name drugs represented only 12 percent of all drugs dispensed, but account for 81 percent of drug spending (see Exhibit 3.1).

Table 3.1: Per Member Per Month Spending on Retail Pharmacy for Rhode Island Residents with Commercial Insurance, Medicaid, or Medicare Advantage Coverage

	All Drugs	Brand Drugs	Generic Drugs
2017	$120	$90	$30
2018	$129	$99	$31
2019	$129 18.7%	$100 27.8%	$29 -9.2%
2020	$139	$109	$29
2021	$142	$116	$27
Average Annual Growth	**4.4%**	**6.4%**	**-2.3%**

Source: OHIC analysis of HealthFacts RI data. Medicare fee-for-service data are excluded.

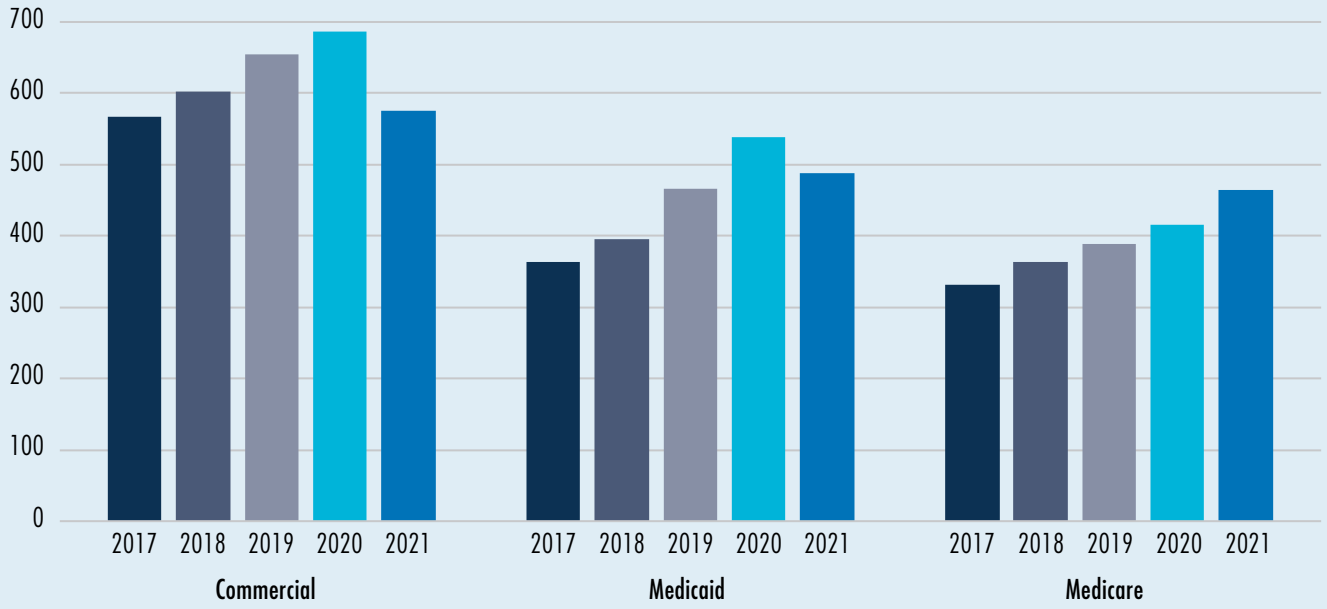
Exhbit 3.1: 2021 Utilization and Spending on Brand and Generic Drugs for Rhode Island Residents with Commercial Insurance, Medicare, or Medicare Advantage Coverage



Source: OHIC analysis of HealthFacts RI data. Medicare fee-for-service data are excluded. Units are defined as 30-day equivalent prescriptions.

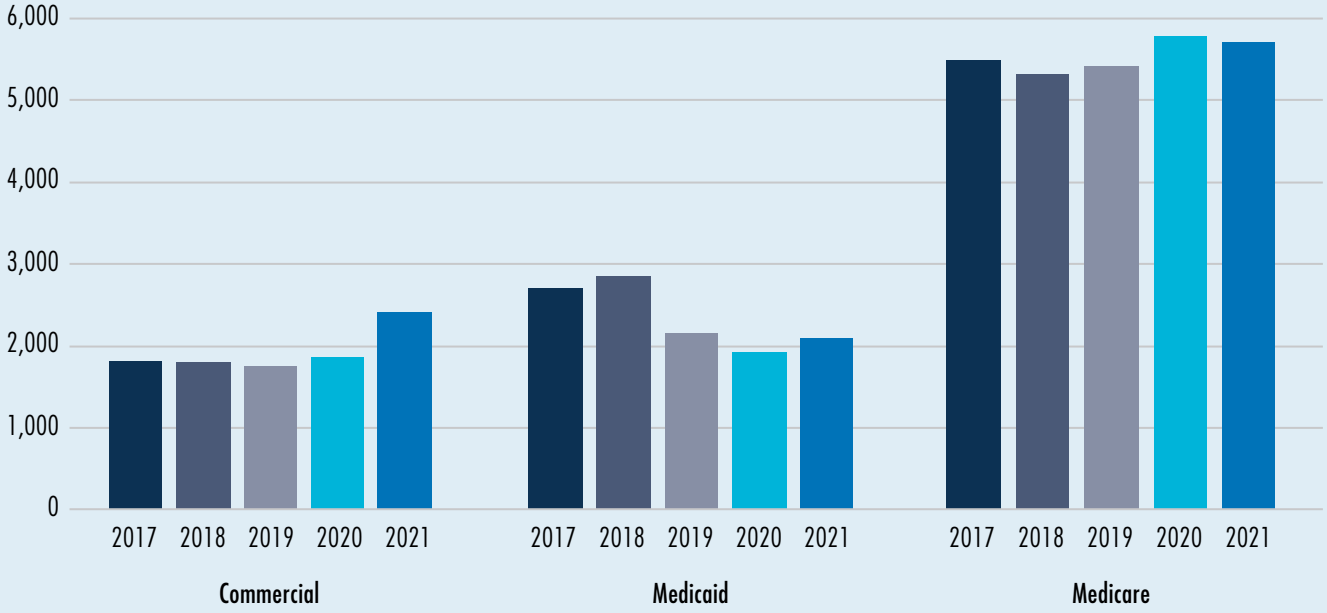
Further analysis shows that price increases drove growth in PMPM spending on brand name drugs. Across all markets, branded drug prices increased steadily between 2017 and 2020 (see Exhibit 3.2), while utilization remained relatively flat or decreased (see Exhibit 3.3).

Exhibit 3.2: Price per Unit of Prescription Drugs



Source: OHIC analysis of HealthFacts RI data. Medicare fee-for-service data are excluded. Units are defined as 30-day equivalent prescriptions.

Exhibit 3.3: Utilization of Prescription Drugs (Units per 1,000 Members)



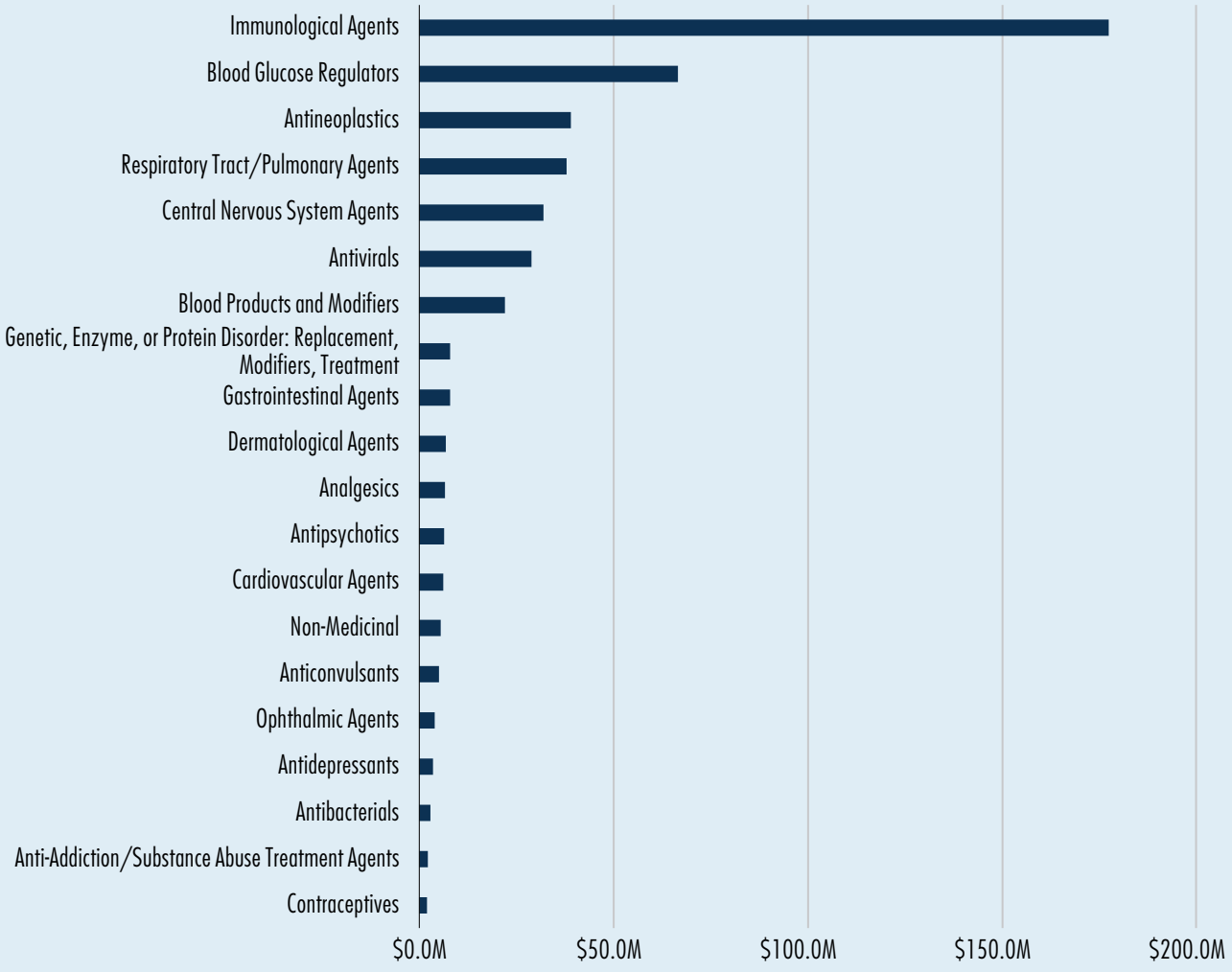
Source: OHIC analysis of HealthFacts RI data. Medicare fee-for-service data are excluded. Units are defined as 30-day equivalent prescriptions.

Trends for 2021 did not follow this general pattern due to the high utilization of COVID-19 vaccines that were subsidized and made available at very low per unit prices. The Pfizer, Moderna, and Janssen COVID-19 vaccines were three of the four most prescribed immunological agents in 2021, with unit prices of approximately $40. Without the COVID-19 vaccines, per unit prices of brand name drugs would have certainly increased in 2021 as well.

Leading Contributors to Prescription Drug Spending in the Commercial Market

To gain a better understanding of what is driving prescription drug spending in the commercial market, OHIC reviewed the seven categories of drugs accounting for almost all of 2021 spending on brand name drugs. Immunological agents topped the list with spending at $177 million (see Exhibit 3.4). A deeper look at leading immunological agent brand drugs shows that per unit prices and annual increases

Exhibit 3.4: Commercial Spending for the Top 20 Brand Name Drug Categories in 2021



Source: OHIC analysis of HealthFacts RI data. Medicare fee-for-service data are excluded.

in per unit prices for these drugs are very high, especially for drugs that have growing market share (see Table 3.2). For example, the Humira (Cf) Pen – a version of a leading anti-inflammatory drug used to treat auto-immune conditions – was introduced into the market in 2019 at a price of $5,740 per unit. Two years after entering the market, the price for the drug increased by 19 percent. The rapid introduction of new and expensive brand name drugs into the market raises significant concerns around affordability for employers and consumers.

Furthermore, research shows that there is often not enough clinical evidence to justify substantial price increases for some major drugs. In 2021, the Institute for Clinical and Economic Review (ICER) reviewed 13 drugs that significantly contributed to growth in U.S. drug spending and found that 10 of them had price increases that were unsupported by new clinical evidence.[1] In previous years, ICER consistently categorized Humira – the highest spend drug in Rhode Island – as a drug with unsupported price increases.[2]

Table 3.2: Change in Commercial Price and Utilization for the Three Leading Immunological Agent Brand Name Drugs

Drug	2017		2021		Change from 2017–2021	
	PRICE PER UNIT	UNITS/1000	PRICE PER UNIT	UNITS/1000	CHANGE IN PRICE PER UNIT	CHANGE IN UNITS/1000
Humira	Not on the market	NA	$6,828	18	19% (since 2019)	80% (since 2019)
Stelara	$9,604	2	$14,624	5	52%	150%
Enbrel Sureclick	$4,431	8	$5,817	7	32%	-13%

Source: OHIC analysis of HealthFacts RI data. Medicare fee-for-service data are excluded.

Prescription drugs are vital to maintaining or improving health. At least half of U.S. individuals and 69 percent of adults aged 40–79 use prescription drugs, and a significant portion of the elderly and those with chronic conditions rely on them to manage their conditions.[3] The high and rising cost of these drugs is putting a financial strain on families, employers, and government. Moving forward, addressing prescription drug costs will be a vital issue for Rhode Island, as the state continues to recover from the pandemic and turns its attention toward containing health care costs over the long term.

1 Institute for Clinical and Economic Review (ICER), *Unsupported Price Increase Report: Unsupported Price Increases Occurring in 2021*, December 6, 2022. https://icer.org/wp-content/uploads/2022/04/UPI_2022_National_Report_120622.pdf.

2 ICER has categorized Humira as a drug with price increases that were not supported by clinical evidence in 2019 and 2020. See: ICER, *Unsupported Price Increase Report: 2019 Assessment*, Updated November 6, 2019, http://icerorg.wpengine.com/wp-content/uploads/2020/10/ICER_UPI_Final_Report_and_Assessment_110619.pdf; and ICER, *Unsupported Price Increase Report: 2020 Assessment*, January 12, 2021. https://icer.org/wp-content/uploads/2020/11/ICER_UPI_2020_Report_011221.pdf.

3 Craig M Hales et al, *Prescription Drug Use Among Adults Aged 40–79 in the United States and Canada*, NCHS Data Brief 347 (2019):1-8, https://pubmed.ncbi.nlm.nih.gov/31442200/.

CHAPTER 4

Quality

To offer a balanced perspective on health system performance, the Rhode Island Cost Trends Steering Committee recommended that OHIC begin reporting quality data to complement annual public reporting of spending growth. Examining quality of care, in conjunction with efforts to aggressively control spending growth, is critical for a comprehensive picture of health system performance.

Since 2017, OHIC has required commercial insurers to use core measures from OHIC's Aligned Measure Sets in any contract with a financial incentive tied to quality.[1,2] In addition, Rhode Island Medicaid's Accountable Entities (AE) program requires measurement and reporting of AE quality performance using the Medicaid AE Common Measure Slate, which EOHHS voluntarily aligns with the OHIC Accountable Care Organization (ACO) Core Measure Set, to inform the distribution of any shared savings earned under total cost of care contracts. For these reasons, and because ACOs and AEs are assessed against the cost growth target, the Cost Trends Steering Committee recommended using OHIC's existing ACO Core Measure Set to monitor quality alongside spending growth.[3]

Starting with the 2021 performance year, OHIC is reporting commercial and Medicaid quality performance data for the Core Measures in OHIC's ACO Aligned Measure Set. This chapter presents these findings.

2021 ACO Core Measure Set

The 2021 ACO Core Measure Set contained the following nine measures addressing three domains: chronic illness, behavioral health, and preventive care:

- Breast Cancer Screening
- Colorectal Cancer Screening
- Comprehensive Diabetes Care: Eye Exam
- Comprehensive Diabetes Care: HbA1c Control (<8.0%)
- Developmental Screening in the First Three Years of Life
- Follow-Up After Hospitalization for Mental Illness (7-Day)
- Weight Assessment and Counseling – BMI Percentile
- Weight Assessment and Counseling – Counseling for Nutrition
- Weight Assessment and Counseling – Counseling for Physical Activity

OHIC obtains commercial performance on the ACO Core Measure Set measures directly from insurers as part of the cost growth target data collection.[4] The Rhode Island EOHHS provides the data to calculate Medicaid performance on the ACO Core Measure Set measures.[5]

1 Rhode Island Code of Regulations, *230-RICR-20-30-4: Powers and Duties of the Office of the Health Insurance Commissioner*, https://ohic.ri.gov/sites/g/files/xkgbur736/files/2022-03/230-ricr-20-30-4-final-sos.pdf.

2 For OHIC's guidance for insurers related to the implementation of its Aligned Measure Sets required under 230-RICR-20-30-4.10(D)(5), see: Office of the Health Insurance Commissioner, *Updated Guidance on Use of Aligned Measure Set*, October 11, 2022, https://ohic.ri.gov/sites/g/files/xkgbur736/files/2022-10/Aligned%20Measure%20Set%20Interpretive%20Guidance%202022%2010-11.pdf.

3 For details on the data collection and analysis methodology, see: OHIC, *Rhode Island Quality Reporting Implementation Manual*, September 21, 2022, https://ohic.ri.gov/sites/g/files/xkgbur736/files/2022-09/RI%20Quality%20Implementation%20Manual_CY2021%20v1.0.pdf.

4 For more information on commercial ACO Core Measure Set data reporting requirements, see: Office of the Health Insurance Commissioner, *Rhode Island Quality Reporting Implementation Manual*, September 1, 2022, https://ohic.ri.gov/sites/g/files/xkgbur736/files/2022-09/RI%20Quality%20Implementation%20Manual_CY2021%20v1.0.pdf.

5 For more information on the AE Common Measure Slate data reporting requirements, see: Rhode Island Executive Office of Health and Human Services, *Rhode Island Accountable Entity Program: Total Cost of Care Quality and Outcome Measures and Associated Incentive Methodologies for Comprehensive Accountable Entities: Implementation Manual*, September 1, 2022, https://eohhs.ri.gov/media/36616/download?language=en.

Statewide Commercial Performance on the ACO Core Measure Set

Rhode Island scored above the national 75th percentile for the commercial market on all the measures, and exceeded the national 90th percentile on all but one of the measures, Comprehensive Diabetes Care: HbA1c Control (see Table 4.1).

Table 4.1: Statewide Commercial Performance on ACO Core Measure Set

Measure	National Benchmarks		Statewide Performance	
	75TH PCTL	90TH PCTL	ABOVE 75TH PCTL?	ABOVE 90TH PCTL?
Breast Cancer Screening	73%	75%	Yes 84%	Yes 84%
Colorectal Cancer Screening	66%	70%	Yes 79%	Yes 79%
Comprehensive Diabetes Care: Eye Exam	54%	60%	Yes 68%	Yes 68%
Comprehensive Diabetes Care: HbA1c Control (<8.0%)	60%	64%	Yes 62%	No 62%
Developmental Screening in the First Three Years of Life	57%	65%	Yes 85%	Yes 85%
Follow-Up After Hospitalization for Mental Illness (7-Day)	53%	59%	Yes 69%	Yes 69%
Weight Assessment and Counseling – BMI Percentile	77%	83%	Yes 92%	Yes 92%
Weight Assessment and Counseling – Counseling for Nutrition	72%	78%	Yes 90%	Yes 90%
Weight Assessment and Counseling – Counseling for Physical Activity	69%	75%	Yes 89%	Yes 89%

Source: OHIC analysis of quality performance data submitted by commercial insurers in Rhode Island. Statewide commercial performance is based on a weighted average of insurer performance using membership from the insurers' cost growth target data submissions, rather than performance for the full population, because multiple insurers submitted population samples.

What Are OHIC's Aligned Measure Sets?

Insurers often provide financial incentives to providers for meeting targets and/or demonstrating improvement on a set of quality measures as a way of encouraging high-quality health care. However, requirements for providers to report their data to multiple insurers who each use a distinct set of measures creates significant provider administrative burden. It also risks diluting the impact of payer incentives by spreading provider attention over a large number of measures. To mitigate these adverse effects, Rhode Island stakeholders undertook a collaborative effort in 2015 to identify a common set of quality measures for use in contracts between insurers and providers.

The Rhode Island State Innovation Model Test Grant supported the initial measure alignment process by convening a work group comprising stakeholders representing insurers, providers, and consumers to develop the measure sets. OHIC now convenes the OHIC Measure Alignment Work Group annually to review and update the Aligned Measure Sets as necessary. OHIC currently maintains aligned measure sets for use in primary care, ACO, acute care hospital, behavioral health hospital, outpatient behavioral health, and maternity care contracts. Each of the measure sets include Core Measures that insurers must use in applicable provider contracts; Menu Measures that are for optional use; and Developmental Measures that need further refinement and/or testing before measure set adoption.

Statewide Medicaid Performance on the ACO Core Measure Set

For 2021, the AE Common Measure Slate did not include Colorectal Cancer Screening, therefore Medicaid performance could only be reported on eight of the nine ACO Core Measures. Rhode Island exceeded the national 75th percentile for the Medicaid market on five measures and exceeded the national 90th percentile on one of the measures (see Table 4.2). Medicaid performance was better for the chronic illness and behavioral health measures than the preventative care measures (with the exception of *Developmental Screening in the First Three Years of Life*). Although the national benchmarks were higher for the Medicaid market than for the commercial market for some measures, Rhode Island's overall performance relative to national benchmarks on the ACO Core Measures was poorer for the Medicaid market than the commercial market, suggesting greater inequity between the two markets in Rhode Island than in other states.

Table 4.2. Statewide Medicaid Performance on ACO Core Measure Set

Measure	National Benchmarks		Statewide Performance	
	75TH PCTL	90TH PCTL	ABOVE 75TH PCTL?	ABOVE 90TH PCTL?
Breast Cancer Screening	57%	61%	Yes 60%	No 60%
Colorectal Cancer Screening	NA	NA	NA	NA
Comprehensive Diabetes Care: Eye Exam	57%	64%	Yes 63%	No 63%
Comprehensive Diabetes Care: HbA1c Control (<8.0%)	54%	58%	Yes 54%	No 54%
Developmental Screening in the First Three Years of Life	57%	65%	Yes 79%	Yes 79%
Follow-Up After Hospitalization for Mental Illness (7-Day)	46%	55%	Yes 54%	No 54%
Weight Assessment and Counseling – BMI percentile	84%	86%	No 83%	No 83%
Weight Assessment and Counseling – Counseling for Nutrition	81%	84%	No 76%	No 76%
Weight Assessment and Counseling – Counseling for Physical Activity	78%	81%	No 74%	No 74%

Source: OHIC analysis of quality performance data of Rhode Island Medicaid managed care organizations obtained from EOHHS. Medicaid performance represents the full population for the measure because EOHHS requires that insurers submit performance for their full population.

CHAPTER 5

Conclusion

Understanding the complicated factors driving health care spending trends is important if Rhode Island is to meet its cost growth target. Three years after OHIC first started analyzing data and reporting on health care spending, a clearer picture is emerging about where health care spending is high and growing quickly, and how COVID-19 has affected trends over the last few years.

The transparency created by collecting, analyzing, and publishing health care spending trends has shone a light on what is driving spending and spending growth in Rhode Island. The data show that pharmaceutical and hospital services represent a significant and fast-growing portion of per capita spending on health care, where the greatest opportunities exist to slow spending growth and thereby improve affordability. In the coming years, addressing pharmacy and hospital spending will be key priorities for OHIC and the Rhode Island Health Care Cost Trends Steering Committee.

That Rhode Island has met the cost growth target in the last two years largely due to the disruptions caused by COVID-19 illustrates the challenges in containing spending growth. Meeting this challenge will require sustained commitment from all stakeholders – including state and local governments, insurers, providers, businesses, and consumers – to implement new and creative approaches to deliver and pay for care in a way that enhances the value of health care. All parties must share accountability for making health care more affordable. Now is the time for all health care stakeholders in the state to commit to action and do our part to take all reasonable and necessary steps to keep annual spending growth below the target while maintaining high standards for quality and access.

Containing spending growth… will require sustained commitment from all stakeholders… to implement new and creative approaches to deliver and pay for care in a way that enhances the value of health care.

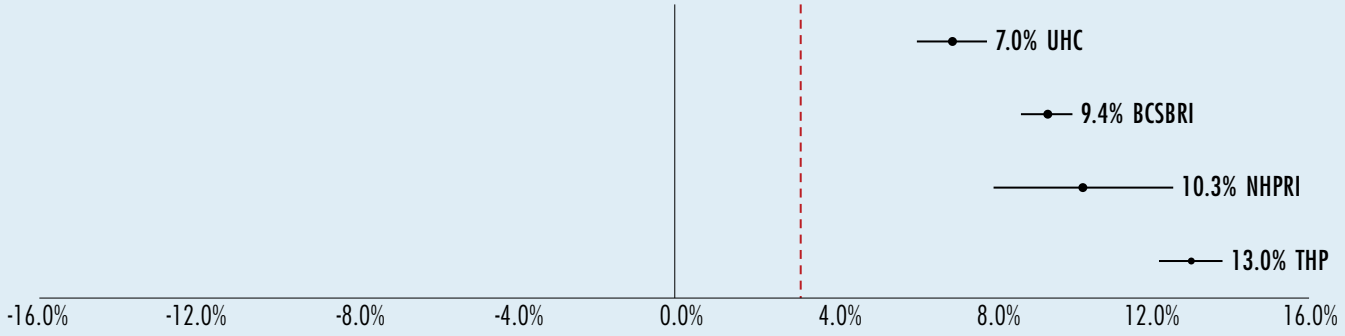
Appendices: Insurer and Provider Cost Growth Target and Quality Performance

Appendix A: Insurer Level Spending Growth

Commercial Insurers' Performance Against the Cost Growth Target

All four commercial insurers exceeded the 3.2% cost growth target for the 2021 performance period. Tufts Health Plan (THP) and Neighborhood Health Plan of Rhode Island's (NHPRI) spending growth exceeded 10% (see Exhibit A.1).

Exhibit A.1: Commercial Insurers' 2021 Performance Against the Cost Growth Target



Source: OHIC analysis of TME data from insurers. Target performance is calculated using TME data, after applying truncation and age/sex risk adjustment. Data represent spending on fully insured and self-insured products, including the Federal Employee Health Benefits Program.

Medicare Advantage Insurers' Performance Against the Cost Growth Target

Both Medicare Advantage insurers exceeded the cost growth target for the 2021 performance period. Spending growth in the commercial and Medicare Advantage markets for both Blue Cross Blue Shield of Rhode Island (BCBSRI) and UnitedHealthcare (UHC) were comparable in 2021; UHC's Medicare Advantage spending growth was higher than its growth in the commercial market, while BCBSRI's Medicare Advantage spending growth was lower than its commercial market growth (see Exhibit A.2).

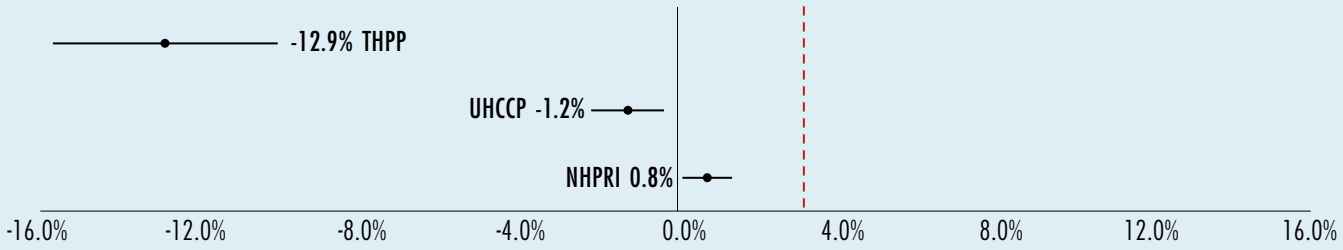
Exhibit A.2: Medicare Advantage Insurers' 2021 Performance Against the Cost Growth Target

Source: OHIC analysis of TME data from insurers. Target performance is calculated using TME data, after applying truncation and age/sex risk adjustment.

Medicaid Insurers' Performance Against the Cost Growth Target

Unlike in the other markets, all Medicaid insurers met the cost growth target. NHPRI was the only Medicaid insurer to experience growth in 2021. UnitedHealthcare Community Plan (UHCCP) and Tufts Health Public Plans' (THPP) PMPM costs decreased, which we suspect were attributed to growth in members as a result of the public health emergency continuous coverage requirement for Medicaid, and the fact that some of those continuously enrolled likely gained commercial coverage. Continuous enrollment had a more dramatic effect for THPP because its membership was comparatively low, magnifying the impact of a large influx of members in 2021. THPP saw a 45 percent increase in membership, while UHCCP and NHPRI's membership grew at approximately 11 percent (see Exhibit A.3).

Exhibit A.3: Medicaid Insurers' 2021 Performance Against the Cost Growth Target



Source: OHIC analysis of TME data from insurers. Target performance is calculated using TME data, after applying truncation and age/sex risk adjustment.

Medicare-Medicaid Plans' Performance Against the Cost Growth Target

Through CMS' Financial Alignment Initiative, Rhode Island provides coverage to individuals who are dually eligible for Medicare and Medicaid through a combined Medicare-Medicaid Plan (MMP). NHPRI was the only insurer to offer such a product in 2021. Target performance is calculated using TME data, after applying truncation. MMP spending is not risk-adjusted, as risk-adjustment is not performed at the market level and NHPRI's population represents the entire population of individuals enrolled in this market.

For the 2021 performance period, NHPRI's MMP spending growth was 4.5 percent, which exceeded the target. MMP enrollees tend to have more complex health care needs and, as a result, higher health care spending per capita.[1] This population may have also experienced more adverse consequences from having to delay care during COVID-19, resulting in higher spending growth.

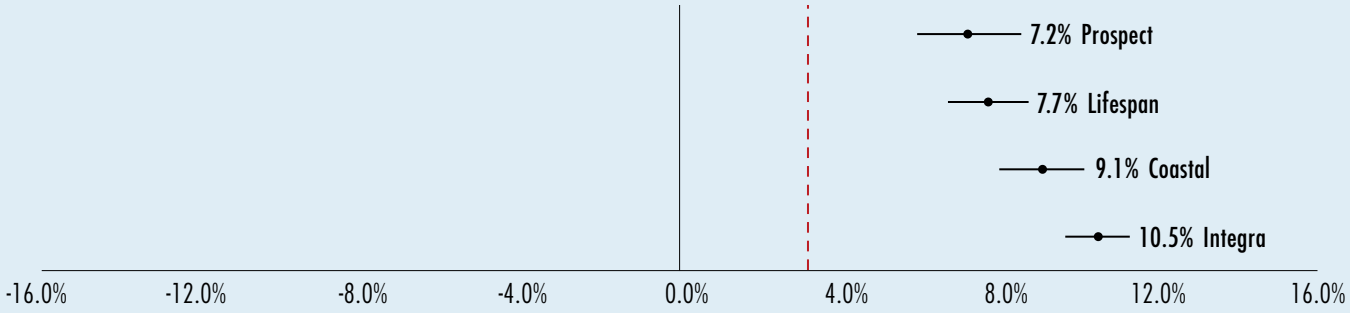
1 For more information on Integrity, see: Neighborhood Health Plan of Rhode Island, *Neighborhood INTEGRITY (Medicare-Medicaid Plan)*, accessed March 27, 2023, https://www.nhpri.org/medicare-medicaid/.

Appendix B: Provider Level Spending Growth

ACOs' Commercial Market Performance Against the Cost Growth Target

2021 commercial growth is not published for Blackstone Valley Community Health Care (BVCHC), Integrated Healthcare Partners (IHP), Providence Community Health Centers (PCHC), or Thundermist Health Center (Thundermist) because they did not have the minimum number of commercial attributed lives required for public reporting.[1] Among the four ACOs that had sufficient attributed lives for performance to be publicly reported, all exceeded the cost growth target for the 2021 performance period (see Exhibit B.1). The range of spending growth of ACOs in the commercial market is similar to that of commercial insurers (7–11 percent for ACOs, 7–13 percent for insurers).

Exhibit B.1: ACOs' 2021 Commercial Market Performance Against the Cost Growth Target

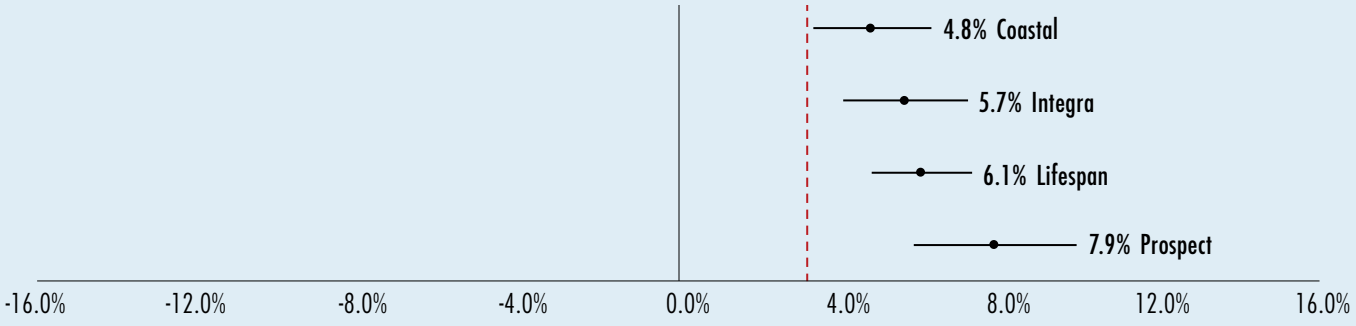


Source: OHIC analysis of TME data from insurers. Target performance is calculated using truncated and age/sex risk-adjusted spending.

ACOs' Medicare Advantage Market Performance Against the Cost Growth Target

2021 Medicare Advantage spending growth is not published for BVCHC, IHP, PCHC, and Thundermist because they did not have the minimum number of Medicare Advantage attributed lives required for public reporting. Among the four ACOs that met the minimum for reporting – which were the same four ACOs that met the threshold for reporting in the commercial market – all exceeded the cost growth target for the 2021 performance period. The range of the ACOs' Medicare Advantage spending growth was similar to the range of their commercial spending growth.

Exhibit B.2: ACOs' 2021 Medicare Market Performance Against the Cost Growth Target



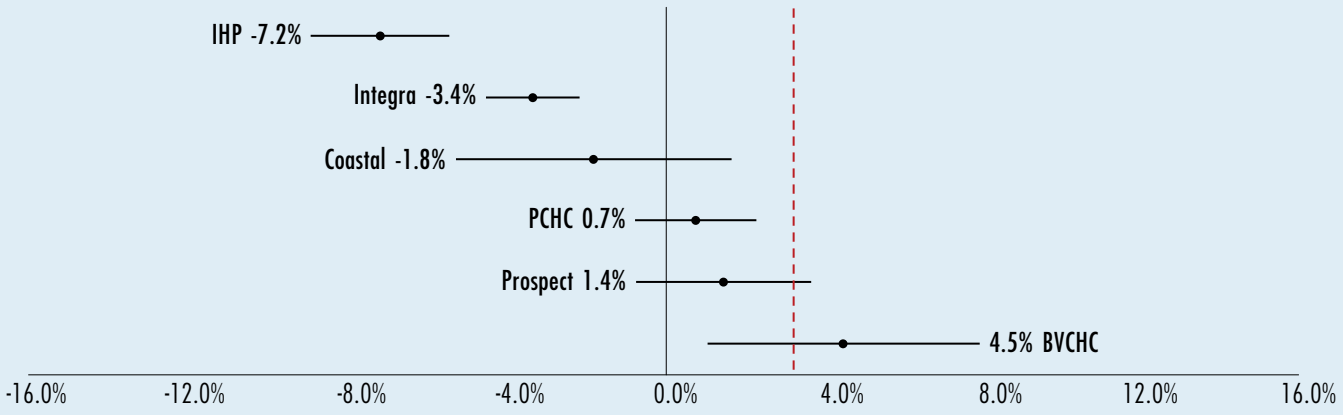
Source: OHIC analysis of TME data from insurers. Target performance is calculated using truncated and age/sex risk-adjusted spending.

1 Insurers and providers must have a minimum of 5,000 attributed lives in the applicable market for their spending growth to be publicly reported.

AEs' Medicaid Market Performance Against the Cost Growth Target

2021 Medicaid spending growth is not presented for Lifespan because it did not hold a total cost of care contract with any Medicaid insurer in 2021. Medicaid spending growth is not presented for Thundermist because it did not have sufficient Medicaid attributed lives in both 2020 and 2021 to meet the minimum required for public reporting. Performance for two AEs (BVCHC and Prospect CharterCARE [Prospect]) could not be assessed based on statistical testing because their confidence interval intersected with the cost growth target. The four remaining AEs met the cost growth target.

Exhibit B.3: AEs' 2021 Medicaid Market Performance Against the Cost Growth Target



Source: OHIC analysis of TME data from insurers. Target performance is calculated using truncated and age/sex-risk adjusted spending.

Appendix C: Insurer Level Performance On Quality

Commercial Insurers' Performance on the ACO Core Measure Set

The three commercial insurers (BCBSRI, THP, and UHC) performed well on the prevention, screening and behavioral health measures but not as well on the diabetes care measures. The three insurers were above the National 75th percentile for all measures, except THP for *Comprehensive Diabetes Care: HbA1c Control (<8.0%).* The insurers were above the 90th percentile for all measures except UHC for *Comprehensive Diabetes Care: Eye Exam* and all three insurers for *Comprehensive Diabetes Care: HbA1c Control (<8.0%)*. BCBSRI's performance compared favorably to the other insurers on three measures: *Breast Cancer Screening, Colorectal Cancer Screening*, and *Comprehensive Diabetes Care: Eye Exam*.

Table C.1: Commercial Insurers' Performance on the ACO Core Measure Set

Measure	National Benchmarks		Above 75th Pctl?			Above 90th Pctl?		
	75TH PCTL	90TH PCTL	BCBSRI	THP	UHC	BCBSRI	THP	UHC
Breast Cancer Screening	73%	75%	Yes 86%	Yes 84%	Yes 78%	Yes 86%	Yes 84%	Yes 78%
Colorectal Cancer Screening	66%	70%	Yes 81%	Yes 73%	Yes 75%	Yes 81%	Yes 73%	Yes 75%
Comprehensive Diabetes Care: Eye Exam	54%	60%	Yes 71%	Yes 63%	Yes 60%	Yes 71%	Yes 63%	No 60%
Comprehensive Diabetes Care: HbA1c Control (<8.0%)	60%	64%	Yes 62%	No 48%	Yes 64%	No 62%	No 48%	No 64%
Follow-Up After Hospitalization for Mental Illness (7-Day)[1]	53%	59%	NA	Yes 75%	Yes 68%	NA	Yes 75%	Yes 68%
Developmental Screening in the First Three Years of Life[2, 3]	57%	65%	Yes 85%	NA	NA	Yes 85%	NA	NA
Weight Assessment and Counseling – BMI percentile	77%	83%	Yes 92%	Yes 88%	Yes 91%	Yes 92%	Yes 88%	Yes 91%
Weight Assessment and Counseling – Counseling for Nutrition	72%	78%	Yes 90%	Yes 87%	Yes 89%	Yes 90%	Yes 87%	Yes 89%
Weight Assessment and Counseling – Counseling for Physical Activity	69%	75%	Yes 89%	Yes 87%	Yes 88%	Yes 89%	Yes 87%	Yes 88%

Source: OHIC analysis of quality performance data submitted by commercial insurers in Rhode Island.

Note: NA = Not Applicable. Insurer did not submit performance on this measure. NHPRI is not included here because it does not have total cost of care contracts with ACOs for their commercial members.

1 BCBSRI did not include *Follow-Up After Hospitalization for Mental Illness* in its 2021 PQIP Program, thus no data were reported for 2021.
2 THP was unable to report a MY 2021 rate for *Developmental Screening in the First Three Years of Life*. THP is working with a vendor and will report this measure for MY 2022.
3 UHC explained to OHIC that they could not report *Developmental Screening in the First Three Years of Life* at the plan level because it is not a HEDIS measure.

Medicaid Insurers' Performance on the ACO Core Measure Set

Medicaid insurers' performance on the ACO Core Measure Set was better for the chronic illness and behavioral health measures than for the preventative care measures. The two Medicaid insurers (NHPRI and UHCCP) were both above the national 75th percentile for *Breast Cancer Screening, Comprehensive Diabetes Care: Eye Exam, Follow-Up After Hospitalization for Mental Illness and Developmental Screening in the First Three Years of Life*. The insurers were above the 90th percentile for only one measure – *Developmental Screening in the First Three Years of Life*.

Table C.2: Medicaid Insurers' Performance on ACO Core Measure Set

Measure	National Benchmarks		Above 75th Pctl?		Above 90th Pctl?	
	75TH PCTL	90TH PCTL	NHPRI	UHCCP	NHPRI	UHCCP
Breast Cancer Screening	57%	61%	Yes 61%	Yes 58%	No 61%	No 58%
Colorectal Cancer Screening	NA	NA	NA	NA	NA	NA
Comprehensive Diabetes Care: Eye Exam	57%	64%	Yes 63%	Yes 61%	No 63%	No 61%
Comprehensive Diabetes Care: HbA1c Control (<8.0%)	54%	58%	Yes 55%	No 53%	No 55%	No 53%
Follow-Up After Hospitalization for Mental Illness (7Day)[4]	46%	55%	Yes 54%	Yes 54%	No 54%	No 54%
Developmental Screening in the First Three Years of Life[5,6]	57%	65%	Yes 80%	Yes 79%	Yes 80%	Yes 79%
Weight Assessment and Counseling – BMI percentile	84%	86%	No 82%	Yes 85%	No 82%	No 85%
Weight Assessment and Counseling – Counseling for Nutrition	81%	84%	No 75%	No 79%	No 75%	No 79%
Weight Assessment and Counseling – Counseling for Physical Activity	78%	81%	No 73%	No 78%	No 73%	No 78%

Source: OHIC analysis of quality performance data of Rhode Island Medicaid managed care organizations obtained from the Rhode Island EOHHS.

Note: NA = Not Applicable. Insurer did not submit performance on this measure. EOHHS does not collect quality data from THPP due to its small population size.

4 BCBSRI did not include *Follow-Up After Hospitalization for Mental Illness* in its 2021 PQIP Program, thus no data were reported for 2021.
5 THPP was unable to report a MY 2021 rate for *Developmental Screening in the First Three Years of Life*. THPP is working with a vendor and will report this measure for MY 2022.
6 UHCCP indicated to OHIC that they could not report *Developmental Screening in the First Three Years of Life* at the plan level because it is not a HEDIS measure.

Appendix D: Provider Level Performance On Quality

ACO Commercial Performance on the ACO Core Measure Set – 75th Percentile

Two ACOs (Coastal Medical [Coastal] and Lifespan) exceeded the 75th percentile for commercial performance for all of the ACO Core Measure Set measures. Integra Community Care Network (Integra) exceeded the 75th percentile for all but one measure – *Comprehensive Diabetes Care: HbA1c Control*. PCHC, Prospect, and Thundermist exceeded the 75th percentile for between one and four measures. BVCHC did not exceed the commercial 75th percentile for any measures. Only one ACO/AE (Integra) had a commercial denominator size large enough (> 30) to report performance on *Follow-Up After Hospitalization for Mental Illness*.

Table D.1: ACO Commercial Performance on the ACO Core Measure Set – 75th Percentile

Measure	National 75th Pctl	Above 75th Pctl?							
		BVCHC	COASTAL	INTEGRA	IHP	LIFESPAN	PCHC	PROSPECT	THUNDERMIST
Breast Cancer Screening	73%	No 64%	Yes 89%	Yes 82%	NA	Yes 89%	Yes 75%	Yes 82%	No 72%
Colorectal Cancer Screening	66%	No 50%	Yes 85%	Yes 78%	NA	Yes 81%	No 61%	Yes 77%	No 53%
Comprehensive Diabetes Care: Eye Exam	54%	No 40%	Yes 75%	Yes 64%	NA	Yes 70%	Yes 57%	Yes 68%	No 53%
Comprehensive Diabetes Care: HbA1c Control (<8.0%)	60%	No 40%	Yes 66%	No 51%	NA	Yes 62%	No 48%	No 60%	No 23%
Follow-Up After Hospitalization for Mental Illness (7Day)	53%	NA	NR	Yes 67%	NA	NR	NR	NR	NA
Developmental Screening in the First Three Years of Life	57%	NR	Yes 95%	Yes 82%	NA	Yes 85%	Yes 73%	Yes 67%	Yes 73%
Weight Assessment and Counseling – BMI percentile	77%	No 64%	Yes 94%	Yes 91%	NA	Yes 90%	No 13%	No 44%	No 37%
Weight Assessment and Counseling – Counseling for Nutrition	72%	No 8%	Yes 93%	Yes 90%	NA	Yes 91%	No 9%	No 38%	No 26%
Weight Assessment and Counseling – Counseling for Physical Activity	69%	No 8%	Yes 92%	Yes 89%	NA	Yes 84%	No 6%	No 27%	No 19%

Source: OHIC analysis of quality performance data submitted by commercial insurers in Rhode Island.

Note:
1. NA = Not Applicable. Insurers did not submit performance on this measure for the ACO/AE.
2. NR = Not Reported. The ACO/AE did not meet the minimum denominator size required for public reporting.

ACO Commercial Performance on the ACO Core Measure Set – 90th Percentile

Only one ACO (Coastal) exceeded the national 90th percentile for commercial performance for all of the ACO Core Measure Set measures. Integra and Lifespan both exceeded the 90th percentile for all but one measure – *Comprehensive Diabetes Care: HbA1c Control*. Prospect exceeded the 90th percentile for all measures except *Comprehensive Diabetes Care: HbA1c Control* and the *Weight Assessment and Counseling* rates. PCHC and THC only exceeded the 90th percentile for *Developmental Screening in the First Three Years of Life*. BVCHC did not exceed the commercial 90th percentile for any measure.

Table D.2: ACO Commercial Performance on the ACO Core Measure Set – 90th Percentile

Measure	National 90th Pctl	Above 90th Pctl?							
		BVCHC	COASTAL	INTEGRA	IHP	LIFESPAN	PCHC	PROSPECT	THUNDERMIST
Breast Cancer Screening	75%	No 64%	Yes 89%	Yes 82%	NA	Yes 89%	No 75%	Yes 82%	No 72%
Colorectal Cancer Screening	70%	No 50%	Yes 85%	Yes 78%	NA	Yes 81%	No 61%	Yes 77%	No 53%
Comprehensive Diabetes Care: Eye Exam	60%	No 40%	Yes 75%	Yes 64%	NA	Yes 70%	No 57%	Yes 68%	No 53%
Comprehensive Diabetes Care: HbA1c Control (<8.0%)	64%	No 40%	Yes 66%	No 51%	NA	No 62%	No 48%	No 60%	No 23%
Follow-Up After Hospitalization for Mental Illness (7-Day)	59%	NA	NR	Yes 67%	NA	NR	NR	NR	NA
Developmental Screening in the First Three Years of Life	65%	NR	Yes 95%	Yes 82%	NA	Yes 85%	Yes 73%	Yes 67%	Yes 73%
Weight Assessment and Counseling – BMI percentile	83%	No 64%	Yes 94%	Yes 91%	NA	Yes 90%	No 13%	No 44%	No 37%
Weight Assessment and Counseling – Counseling for Nutrition	78%	No 8%	Yes 93%	Yes 90%	NA	Yes 91%	No 9%	No 38%	No 26%
Weight Assessment and Counseling – Counseling for Physical Activity	77%	No 8%	Yes 92%	Yes 89%	NA	Yes 84%	No 6%	No 27%	No 19%

Source: OHIC analysis of quality performance data submitted by commercial insurers in Rhode Island.

Note:
1. NA = Not Applicable. Insurers did not submit performance on this measure for the ACO/AE.
2. NR = Not Reported. The ACO/AE did not meet the minimum denominator size required for public reporting.

AE Medicaid Performance on the ACO Core Measure Set – 75th Percentile

Two AEs (Coastal and PCHC) exceeded the national 75th percentile for Medicaid performance for all the ACO Core Measure Set measures. BVCHC exceeded the 75th percentile for all the measures except for *Comprehensive Diabetes Care: Hba1c Control* and two of the *Weight Assessment and Counseling* rates. Integra and Prospect exceeded the 75th percentile for four of the measures, with worse performance for the *Weight Assessment and Counseling* rates and the diabetes measures. IHP and Thundermist exceeded the 75th percentile for two and three measures, respectively. All ACOs/AEs exceeded the 75th percentile for *Follow-Up After Hospitalization for Mental Illness* and all but one ACO/AE exceeded the 75th percentile for *Developmental Screening in the First Three Years of Life*.

Table D.3: AE Medicaid Performance on the ACO Core Measure Set – 75th Percentile

Measure	National 75th Pctl	Above 75th Pctl?							
		BVCHC	COASTAL	INTEGRA	IHP	LIFESPAN	PCHC	PROSPECT	THUNDERMIST
Breast Cancer Screening	57%	Yes 59%	Yes 75%	Yes 58%	No 51%	NA	Yes 64%	Yes 62%	No 53%
Colorectal Cancer Screening	NA	NA	NA	NA	NA	NA	NA	NA	NA
Comprehensive Diabetes Care: Eye Exam	57%	Yes 67%	Yes 73%	No 56%	No 51%	NA	Yes 73%	Yes 60%	Yes 58%
Comprehensive Diabetes Care: HbA1c Control (<8.0%)	54%	No 52%	Yes 62%	No 49%	Yes 64%	NA	Yes 57%	No 51%	No 54%
Follow-Up After Hospitalization for Mental Illness (7-Day)	46%	Yes 56%	Yes 64%	Yes 55%	Yes 51%	NA	Yes 54%	Yes 50%	Yes 51%
Developmental Screening in the First Three Years of Life	57%	Yes 91%	Yes 93%	Yes 75%	No 56%	NA	Yes 82%	Yes 78%	Yes 78%
Weight Assessment and Counseling – BMI percentile	84%	Yes 87%	Yes 94%	Yes 85%	No 76%	NA	Yes 87%	No 53%	No 73%
Weight Assessment and Counseling – Counseling for Nutrition	81%	No 72%	Yes 89%	No 77%	No 56%	NA	Yes 81%	No 51%	No 71%
Weight Assessment and Counseling – Counseling for Physical Activity	78%	No 70%	Yes 89%	No 76%	No 55%	NA	Yes 81%	No 38%	No 70%

Source: OHIC analysis of quality performance data of Rhode Island Medicaid managed care organizations obtained from the Rhode Island EOHHS.

NA = Not Applicable. Insurers did not submit performance on this measure for the ACO/AE.

AE Medicaid Performance on the ACO Core Measure Set – 90th Percentile

Only one AE (Coastal) exceeded the national 90th percentile for Medicaid performance for all the ACO Core Measure Set measures. BVCHC and PCHC exceeded the 90th percentile for half of the measures. Integra and Prospect exceeded the 90th percentile for two measures each. IHP and Thundermist exceeded the 90th percentile for one measure each (*Comprehensive Diabetes Care: HbA1c Control and Developmental Screening in the First Three Years of Life*, respectively). All but one AE exceeded the 90th percentile for *Developmental Screening in the First Three Years of Life*.

Table D.4: AE Medicaid Performance on the ACO Core Measure Set – 90th Percentile

Measure	National 90th Pctl	Above 90th Pctl?							
		BVCHC	COASTAL	INTEGRA	IHP	LIFESPAN	PCHC	PROSPECT	THUNDERMIST
Breast Cancer Screening	61%	No 59%	Yes 75%	No 58%	No 51%	NA	Yes 64%	Yes 62%	No 53%
Colorectal Cancer Screening	NA	NA	NA	NA	NA	NA	NA	NA	NA
Comprehensive Diabetes Care: Eye Exam	64%	Yes 67%	Yes 73%	No 56%	No 51%	NA	Yes 73%	No 60%	No 58%
Comprehensive Diabetes Care: HbA1c Control (<8.0%)	58%	No 52%	Yes 62%	No 49%	Yes 64%	NA	No 57%	No 51%	No 54%
Follow-Up After Hospitalization for Mental Illness (7Day)	55%	Yes 56%	Yes 64%	Yes 55%	No 51%	NA	No 54%	No 50%	No 51%
Developmental Screening in the First Three Years of Life	65%	Yes 91%	Yes 93%	Yes 75%	No 56%	NA	Yes 82%	Yes 78%	Yes 78%
Weight Assessment and Counseling – BMI percentile	86%	Yes 87%	Yes 94%	No 85%	No 76%	NA	Yes 87%	No 53%	No 73%
Weight Assessment and Counseling – Counseling for Nutrition	84%	No 72%	Yes 89%	No 77%	No 56%	NA	No 81%	No 51%	No 71%
Weight Assessment and Counseling – Counseling for Physical Activity	81%	No 70%	Yes 89%	No 76%	No 55%	NA	No 81%	No 38%	No 70%

Source: OHIC analysis of quality performance data of Rhode Island Medicaid managed care organizations obtained from the Rhode Island EOHHS.

NA = Not Applicable. Insurers did not submit performance on this measure for the ACO/AE.