Rhode Island Health Spending Accountability and Transparency Program
Steering Committee Meeting Minutes
EOHHS – Virks Building – 3 West Road, Cranston
January 19, 2024
1:30-3:00pm

Steering Committee Attendees:
Cory King, Office of the Health Insurance Commissioner
Ed McGookin, Coastal Medical
Stephanie de Abreu, UnitedHealthcare
Al Charbonneau, Rhode Island Business Group on Health
Pat Flanagan, CTC-RI
Mark Jacobs
Teresa Paiva Weed, Hospital Association of Rhode Island
Representatives on behalf of Peter Marino, Neighborhood Health Plan of Rhode Island
Daniel Moynihan (on behalf of John Fernandez), Lifespan
Sam Salganik, Rhode Island Parent Information Network
Larry Warner, United Way
Larry Wilson, The Wilson Organization

Unable to Attend:
Tim Archer, UnitedHealthcare
David Cicilline, Rhode Island Foundation
Patrick Crowley, RI AFL-CIO
Michael DiBiase, Rhode Island Public Expenditure Council
Diana Franchitto, Hope Health
Peter Hollmann, Rhode Island Medical Society
Michele Lederberg, Blue Cross Blue Shield Rhode Island
Jim Loring, Amica Mutual Insurance Company
Kate Skouteris, Point32Health
Michael Wagner, Care New England

I. Welcome
Ed McGookin welcomed Steering Committee members to the January meeting and reviewed the agenda.

II. Approve Meeting Minutes
Ed McGookin asked if Steering Committee members had any comments on the October 20th meeting minutes. The Steering Committee voted to approve the October meeting minutes with no opposition or abstentions.

III. Blue Cross and Coastal presentation on their primary care capitation arrangement
Cory King reminded the attendees that during the last meeting he had shared his assessment that it was evident that not all payers or hospitals in the state were interested in advancing VBP as originally envisioned in the April 2022 Compact. Despite this, he wanted to highlight the collaborative effort between Blue Cross Blue Shield of Rhode Island (BCBSRI) and Coastal Medical to implement prospective payment for primary care (i.e., primary care capitation). He turned first to invited guests Cathy Newman and Nick Lefeber of BCBSRI to speak on the arrangement from their perspective.

Nick Lefeber stated that primary care capitation was one "tool in the toolkit" to support better health care delivery in Rhode Island. Cathy Newman added that this tool provided a predictable stream of revenue for providers, supported team-based care, and reduced burnout among providers, as it solved their financial reliance on patients coming in for visits.

Ed McGookin explained that at Coastal Medical, the retirement of four physicians and the subsequent discharge of patients from their medical home created a "perfect storm" for Coastal to examine how it could continue to support these patients while also avoiding burnout among staff. To navigate this challenge, the Coastal team developed the Patient Support Model, which included teams of skilled practitioners and administrative staff to support physicians. Ed shared that based on 2023 data, physicians participating in the Patient Support Model reported higher job satisfaction and less burnout than non- Patient Support Model physicians. While he celebrated the model's benefits for Coastal, he emphasized the need to ensure such a model could benefit practices of all sizes in the state.

- Teresa Paiva Weed asked why the burnout rate in Rhode Island was higher than the national average.
    - Ed McGookin noted that the national benchmarks were set in 2015, and that the phenomenon Teresa described was likely due to administrative burden felt by primary care physicians (PCPs). One conservative estimate he offered was that physicians spend one or two hours of administrative work for every one hour of patient care.
- Sam Salganik asked whether Coastal had a vision to include community health workers (CHWs) in the Patient Support Model, and what measures Coastal had in place to mitigate against the stinting of care.
    - Ed McGookin acknowledged that CHWs were foundational to behavioral health care and intended to include them in the creation of multidisciplinary teams for behavioral health care. As for stinting, Ed shared that Coastal's contracts stated that providers could not share in savings unless they also performed adequately on quality metrics.
    - Cathy Newman added that it was important to be in dialogue with providers to understand any unusual trends in their performance data.
- Mark Jacobs asked whether Coastal profited from capitated payments.
    - Ed McGookin replied that Coastal did, and that it could not have done so without financial help from Lifespan.

Cory King noted that the BCBSRI and Coastal's arrangement highlighted why committing to payment reform was crucial, as it unlocks opportunities for innovative staffing models such as the one Ed described. OHIC-initiated conversations about PCP capitation began in 2017, and he

reveled in seeing them coming to fruition. He thanked Blue Cross for investments in infrastructure and operational capacity to make this possible.

IV. Review of Steering Committee's work since 2018

Michael Bailit summarized five notable accomplishments of the Steering Committee from the last five years; it 1) established both the second cost growth target in the country, and a routine and reliable process to collect, analyze, and report on state health care spending data, 2) created and signed a value-based payment compact in 2022, 3) developed a hospital global budget design, 4) adopted public health and health equity measures and targets, and 5) adopted cost growth targets for 2023-2027 under a new compact. He noted an additional accomplishment was that even in times of turnover within their organizations, Committee members ensured their organization was represented on the Steering Committee.

As for items the Committee had not achieved, Michael observed that it had not carried out all actions laid out in the 2022 VBP compact, nor had it agreed upon a specific strategy to address rising drug prices. Michael reminded everyone that pharmacy prices were a cost driver for all markets in Rhode Island.

V. Future role and purpose of the Steering Committee

Cory King reminded participants that the Steering Committee initially came together in 2018 to "provide Rhode Island citizens with high-quality, affordable health care through greater transparency of health care performance and increased accountability by key stakeholders." He invited members to reflect on whether the Committee could continue to be an effective agent and fulfill its purpose of advancing affordability in the state, and for specific actions for which the group could commit.

- Teresa Paiva Weed commented that one challenge of the Steering Committee was that it focused exclusively on the commercial market, but felt that it still served a valuable purpose. She believed the Committee could be effective, but only if the discussions could be broader than just focusing on pharmacy.
- Al Charbonneau commented that this body was the appropriate venue to discuss payment reform in the state.
- Dan Moynihan noted that each year of cost trends data analysis pointed to pharmacy spending as an area of opportunity for cost mitigation. He supported that pursuit but suggested that the Committee also look into specialist utilization.
- Mark Jacobs shared his opinion that the Committee could be more effective if decision-makers in the organizations represented attended these meetings.
- Larry Warner asked Cory whether he felt that the Committee fulfilled its original purpose. He noted that there did not exist accountability mechanisms for stakeholders outside of data transparency, given the voluntary nature of reporting on cost trends, and asked whether there were other mechanisms to keep stakeholders accountable.
    - Cory King acknowledged that there were no formal accountability mechanisms for payers and providers, and knew that there would be disagreement in the state on how those would come together. He wanted this group to come up with a solution on how the state could continuously meet the cost growth target in the future. Based on comments so far, he heard a desire to continue convening the Committee, at least as a group that fashioned principles and actions. He noted that one opportunity to engage in care delivery reform was under CMMI's

Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model.

VI. CMMI AHEAD Model

Michael Bailit provided an overview of the AHEAD model by detailing the model's purpose and goals, providing historical context on CMMI's payment models with select states (i.e., MD, PA, and VT), summarizing key components of the model, walking through CMMI's rationale for including hospital global budgets in the model, and explaining the funding and timeline for this model.

Cory King then explained why Rhode Island was a strong candidate for the model (e.g., RI had a statewide cost growth target and a commercial market primary care spend obligation and had activities in place to advance health equity). He noted that the state would have to decide on whether or not to apply for one of the eight spots CMS offered for this model, highlighting that what CMMI presented was compatible with the Steering Committee's principles of promoting affordability and improving health care delivery. He acknowledged that CMS had yet to publish specifications on hospital global budgets, and how they would interact with preexisting Medicare shared savings programs.

- Stephanie de Abreu asked whether hospitals could commit for shorter time periods (e.g., three years instead of the full 11 years).
    - Cory King replied that hospitals could join during a later measurement year (e.g., MY6 instead of MY4), but had to stay on until completion of the Model. If they exited earlier, they would have to pay the transformation incentive adjustment back to Medicare.
- Mark Jacobs asked whether the states with prior experience with state payment models operated by CMMI (i.e., Maryland, Pennsylvania, and Vermont) employed primary care capitation or global payments for primary care.
    - Michael Bailit responded that Maryland and Vermont had mature primary care initiatives that were independent of hospital global budgets, that included some primary care capitation. He did not know the answer for Pennsylvania.

VII. Public Comment

- There were no public comments.

VIII. Next Steps and Wrap-Up

The next Steering Committee meeting will be scheduled in April 2024 and the annual Cost Trends public forum will be held on May 13th from 9:00am – 12:00pm at the Crowne Plaza in Warwick.