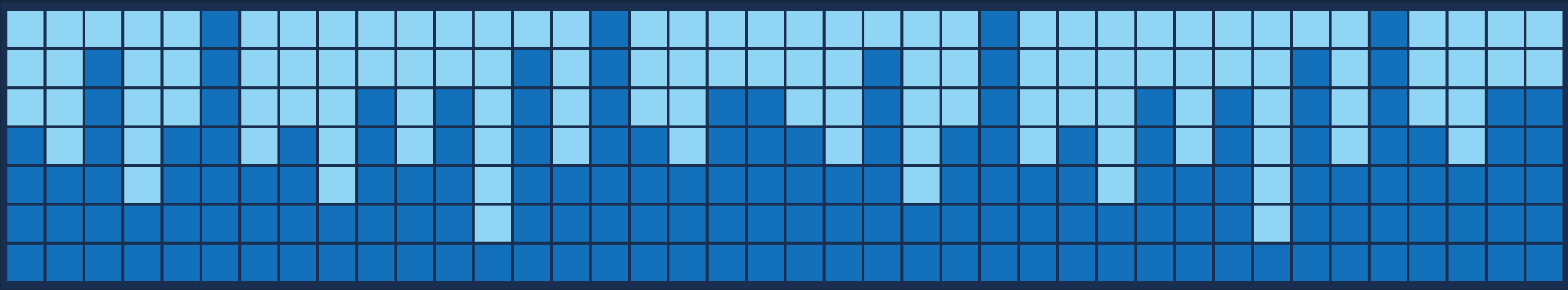
STATE OF RHODE ISLAND
Office of The Health Insurance Commissioner
Department of Business Regulation

Health Care Spending and Quality in Rhode Island

2024



Agenda

1. Cost Growth Target Background
2. Performance Against the Cost Growth Target
   - State & Market
   - Service Category Trends
   - Insurer
   - ACO/AE
3. Cost Driver Analyses using the All-Payer Claims Database
4. Statewide and Market-Level Quality Performance
5. Baseline Performance on Public Health and Health Equity Measures

Cost Growth Target Background

Rhode Island's Cost Growth Target

In 2018, the Rhode Island Cost Trends Steering Committee set out to restrain health care spending growth and improve affordability of health care by establishing a cost growth target.

- The Committee established a statewide per person annual cost growth target of 3.2%, equivalent to long-term projections of the State's economic growth. This target was applicable for the 2019 through 2022 performance years.
- In 2023, the Committee selected a set of new targets for 2023 through 2027 (memorialized in an updated voluntary Compact) that consider both projected state economic and median household income growth. Inclusion of the latter was in recognition that consumer impact needed to be reflected in the targets.

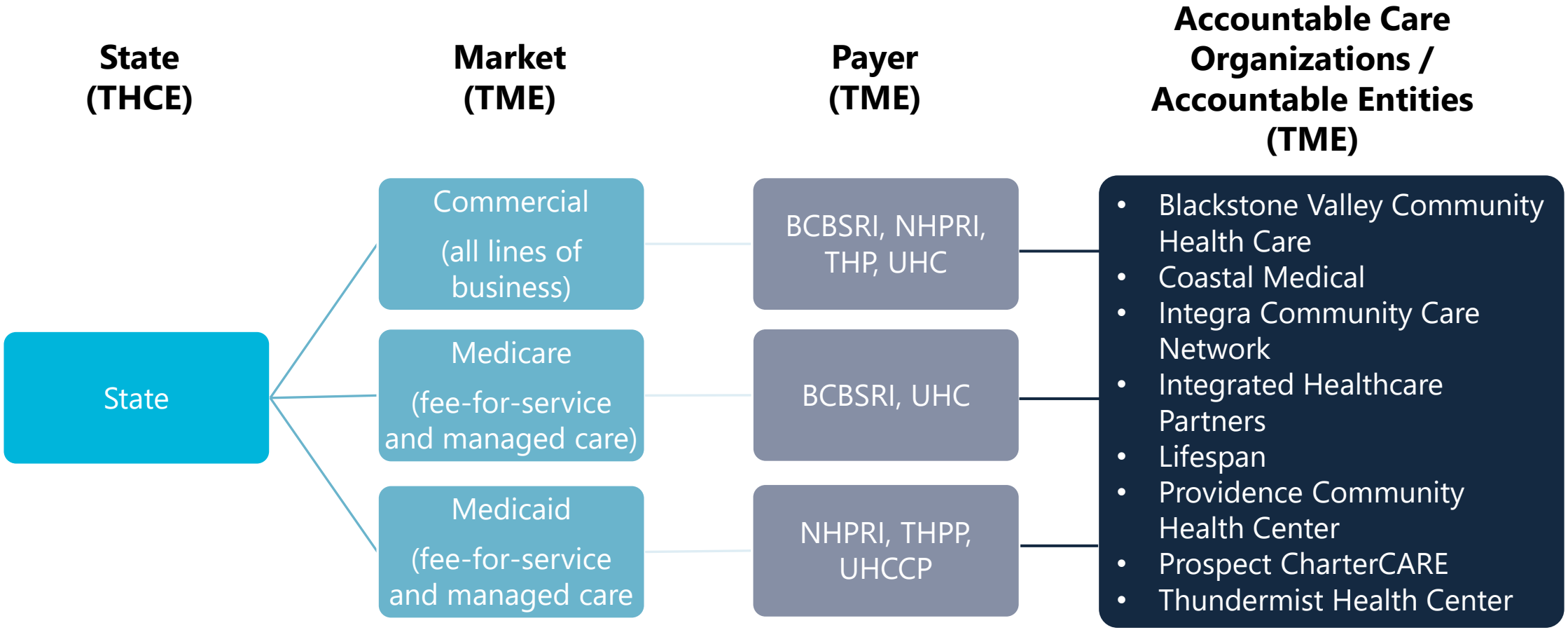
Besides Rhode Island, there are now seven other states (CA, CT, DE, MA, NJ, OR, and WA) that have cost growth target programs.

What Is Being Measured Against the Target

Total Medical Expense (TME) + **Net Cost of Private Health Insurance (NCPHI)** = **Total Health Care Expenditures (THCE)**

- **Total Medical Expense (TME):** All incurred expenses for RI residents for all health care services, regardless of where the care was delivered and regardless of the situs of the member's plan.
- **Net Cost of Private Health Insurance (NCPHI):** The costs to RI residents associated with the administration of private health insurance.

Four Levels of Performance Measurement Against the Target



An Addition to This Year's Reporting

Included in the updated Cost Trends Compact is a commitment to advancing **public health and health equity** in tandem with improvements in health care affordability. At the Cost Trends Steering Committee's recommendation, OHIC convened its Public Health and Health Equity Measures Work Group to select a set of public health and health equity measures with associated targets, with the intention that results be reported publicly.

The Work Group recommended six measures spanning four domains (childhood obesity, behavioral health, health care access, and maternal and infant health).

Today, in addition to reporting on state and market-level performance on OHIC's ACO Aligned Measure Set, OHIC will report baseline performance on these public health and health equity measures. 2025 will serve as the first performance period.

Important Notes for Today's Presentation (1 of 2)

Today's presentation includes analyses using data from both the cost growth target data collection and analyses using data from the All-Payer Claims Database.

Analyses using APCD data are not directly comparable with analyses using cost growth target data because of the inclusion or exclusion of:

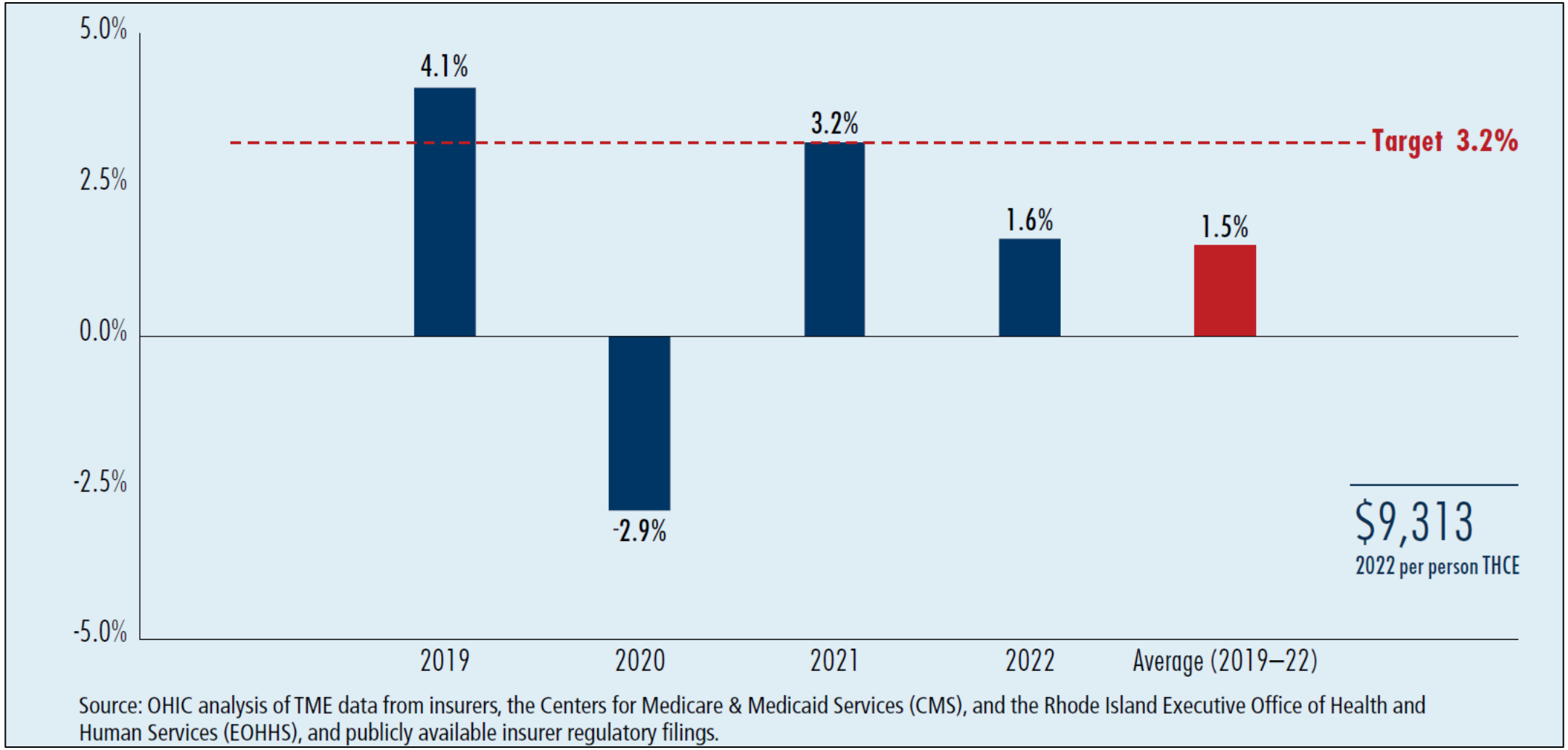
- non-claims payments,
- total spending for the self-insured population, and
- pharmacy rebates.

Important Notes for Today's Presentation (2 of 2)

- Rhode Island's APCD does not contain all spending associated with residents with commercial market coverage due to the State's inability to require claims submissions from self-insured employers (although some do voluntarily submit data).
  - This contrasts with the data submitted by payers as part of the Cost Growth Target data collection, which includes data for all state residents, including those covered by both fully insured plans and self-insured plans.
- Based on OHIC's analysis, approximately 80 percent of total commercial spending, and 80 percent of commercially covered lives in the state are represented in the APCD.

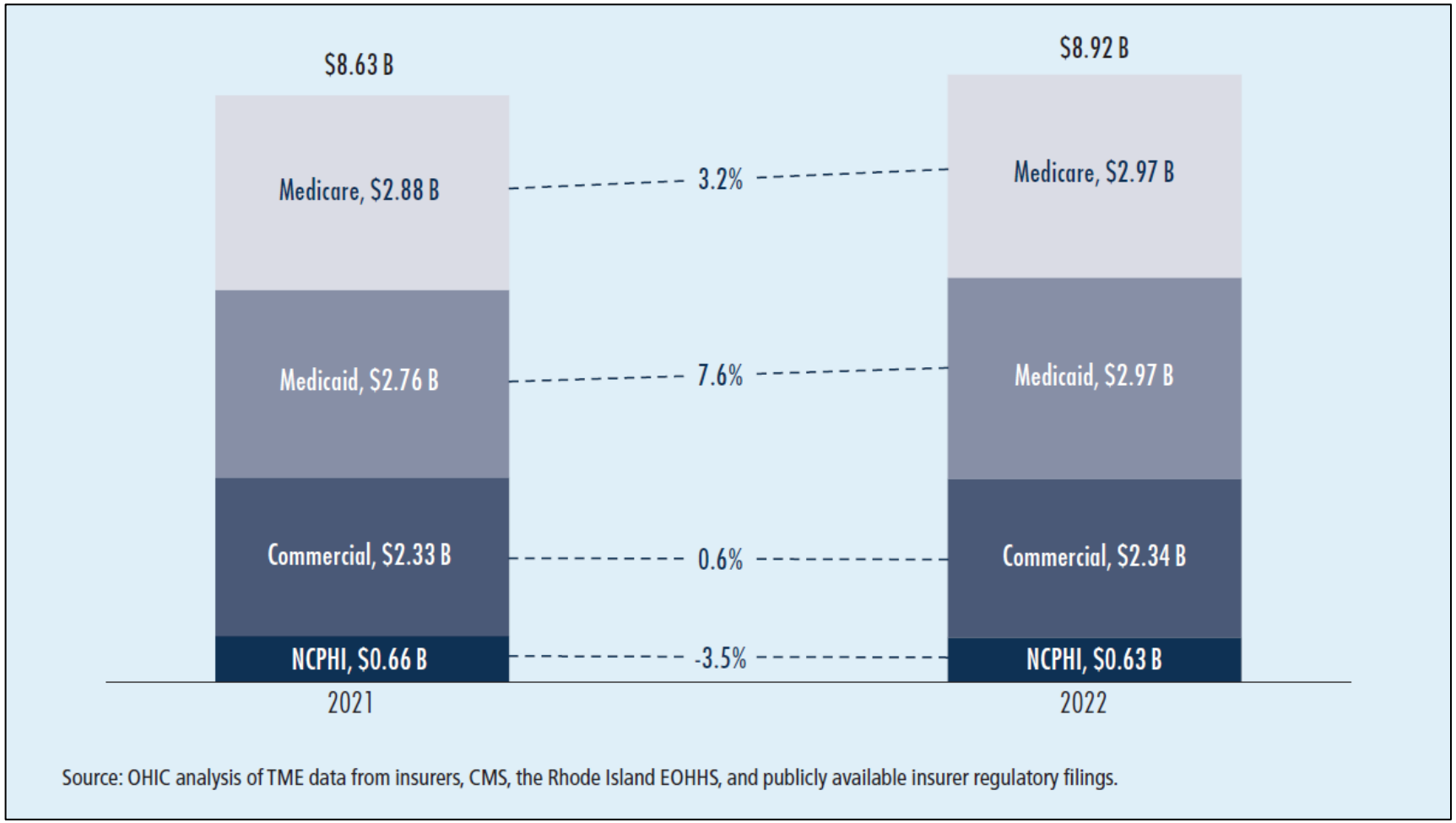
State & Market Performance Against the Cost Growth Target

Rhode Island Met its Cost Growth Target in 2022



Data are not risk-adjusted and are reported net of pharmacy rebates.

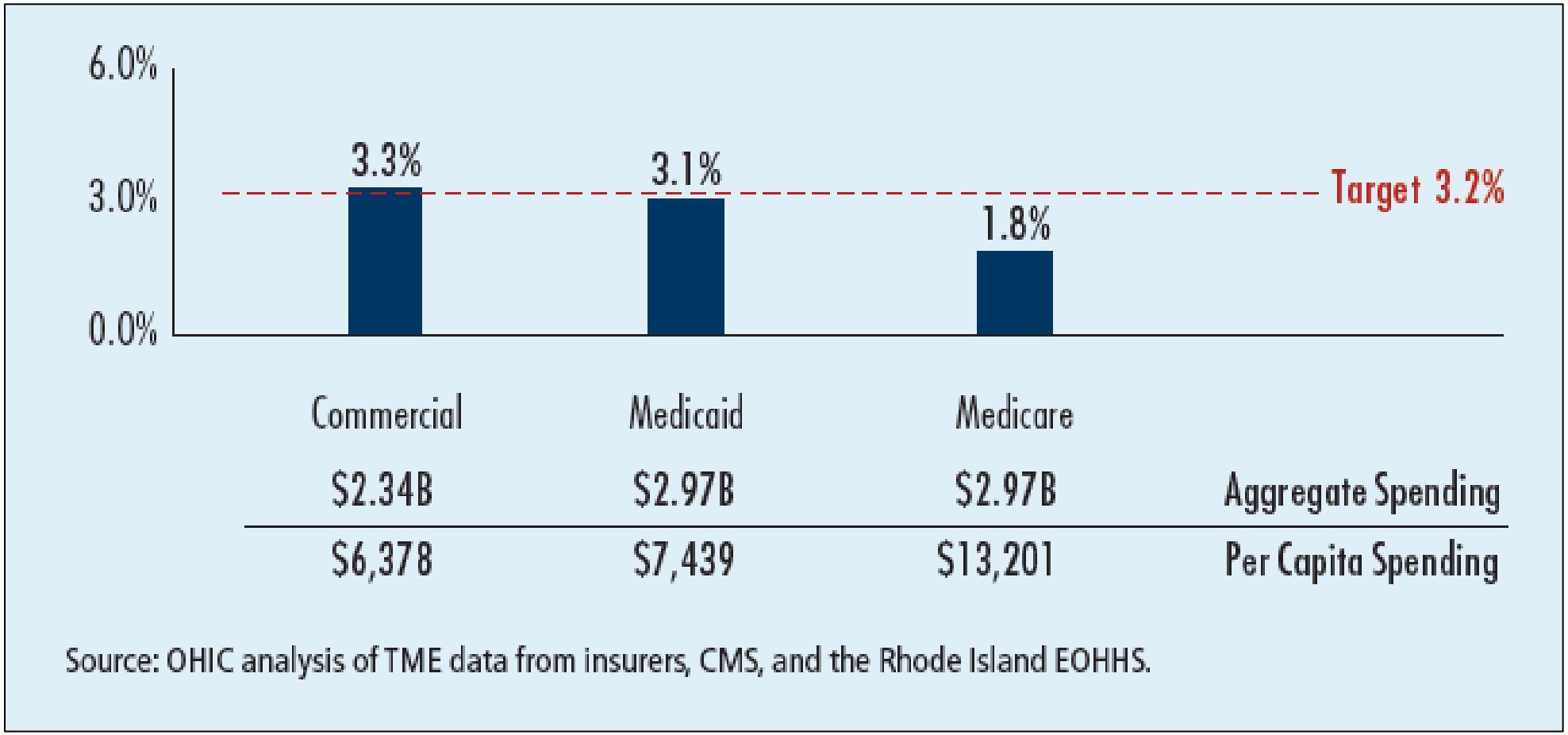
Total Health Care Spending in Rhode Island Was $8.92 Billion in 2022



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

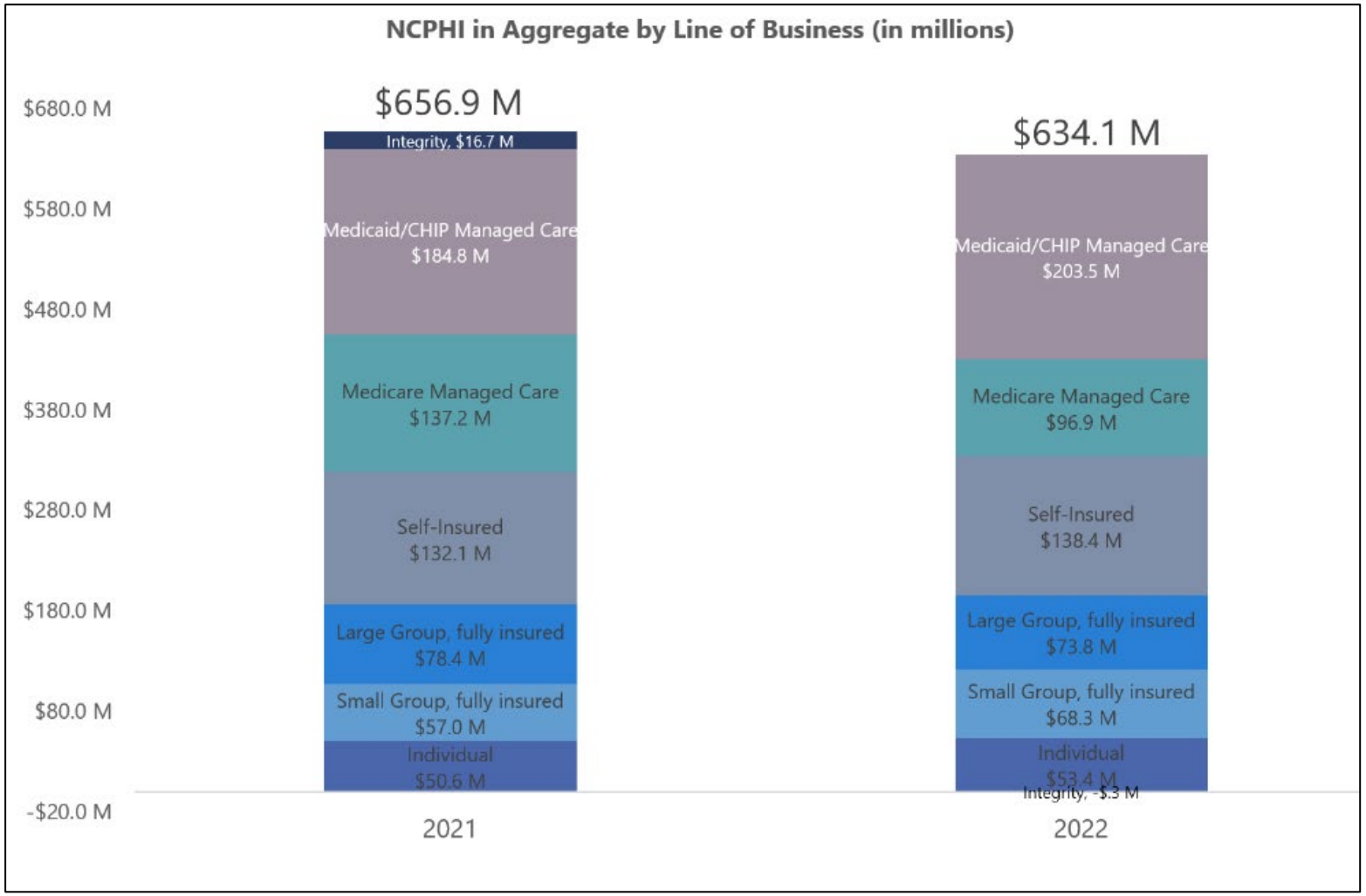
Data are not risk-adjusted and are reported net of pharmacy rebates. "NCPHI" is the Net Cost of Private Health Insurance.

Growth in the Commercial Market Slightly Exceeded the Cost Growth Target; Growth in Medicaid was Just Under



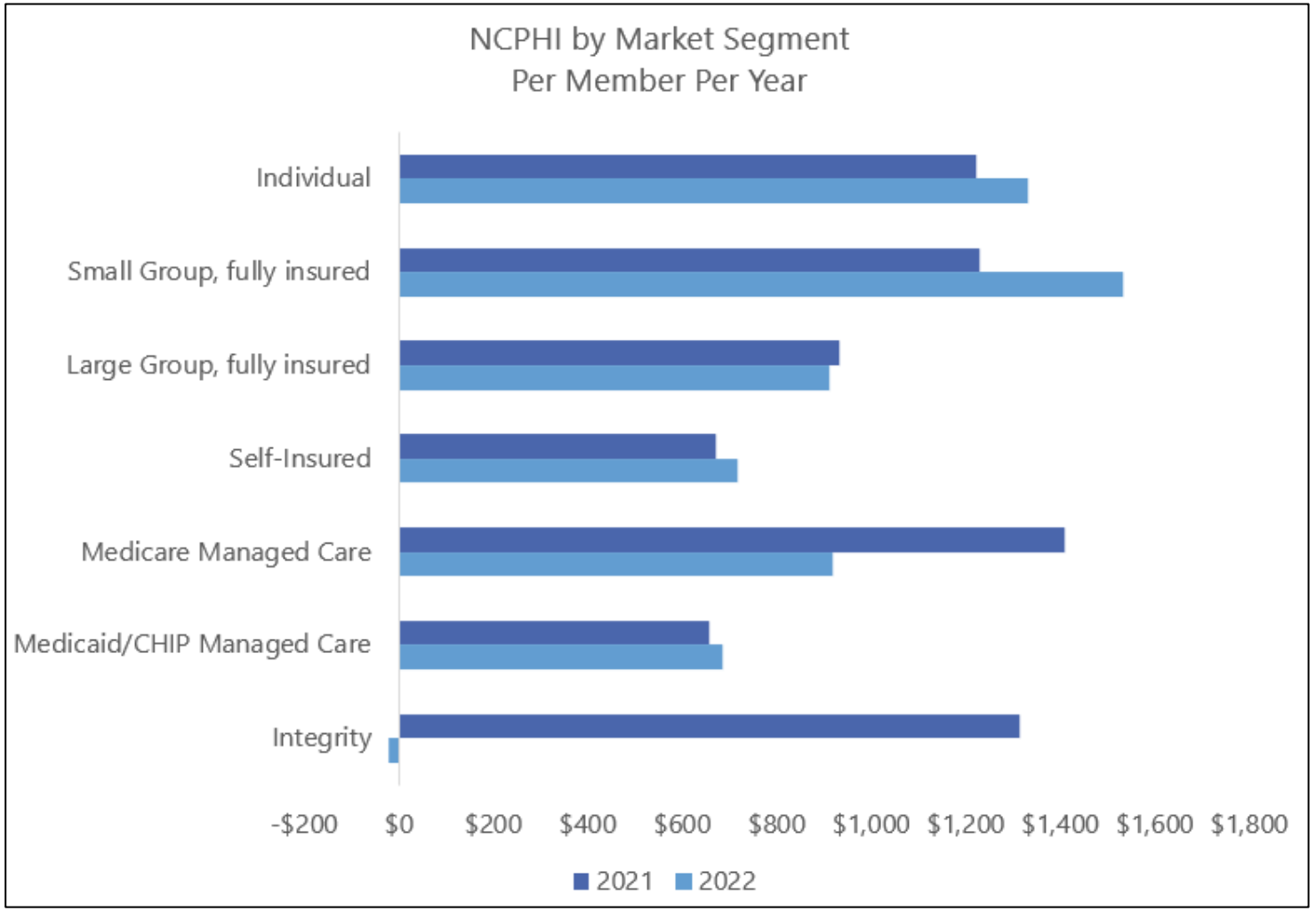
Note: Statewide THCE trend in 2022 was 1.6%, which is below that of each of the three markets shown here. THCE includes NCPHI, which decreased on a per capita basis by 5%. Additionally, in both 2021 and 2022, per capita spending for Medicare was nearly equal to the sum of per capita spending in the commercial and Medicaid markets. Medicare's low growth brought overall statewide trend down.

In 2022, NCPHI Decreased 3.5% and Contributed $634 Million to State THCE



Year	NCPHI Per Capita	NCPHI Trend Per Capita
2021	$698	-5.1%
2022	$662	

NCPHI by Market Segment

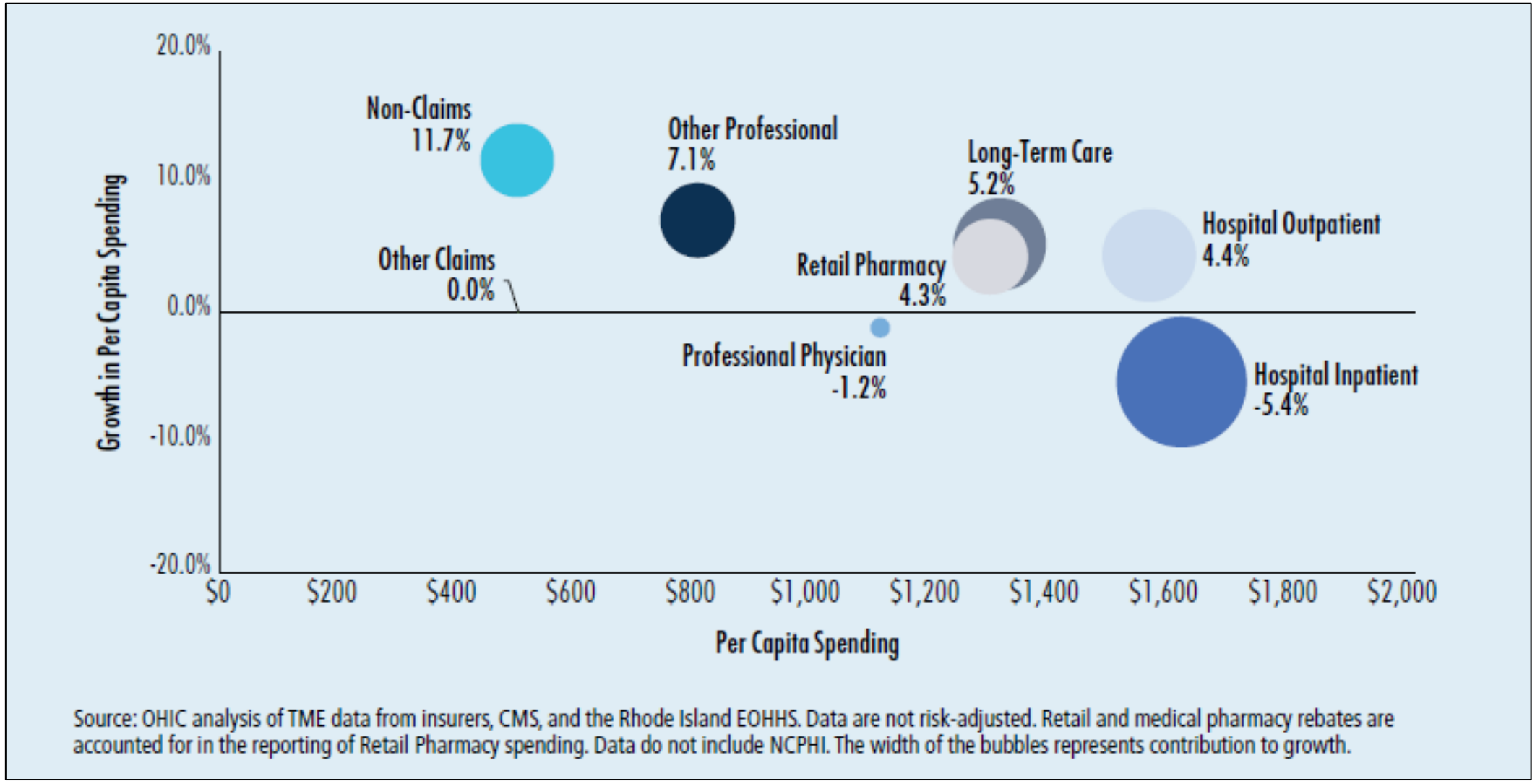


Aggregate NCPHI
2021: $657M
2022: $634M

Category	2021-2022 Trend
Individual	9%
Small Group	25%
Large Group	-2%
Self-Insured	7%
Medicare MCO	-35%
Medicaid MCO	4%
FAI Duals (Integrity)	-102%

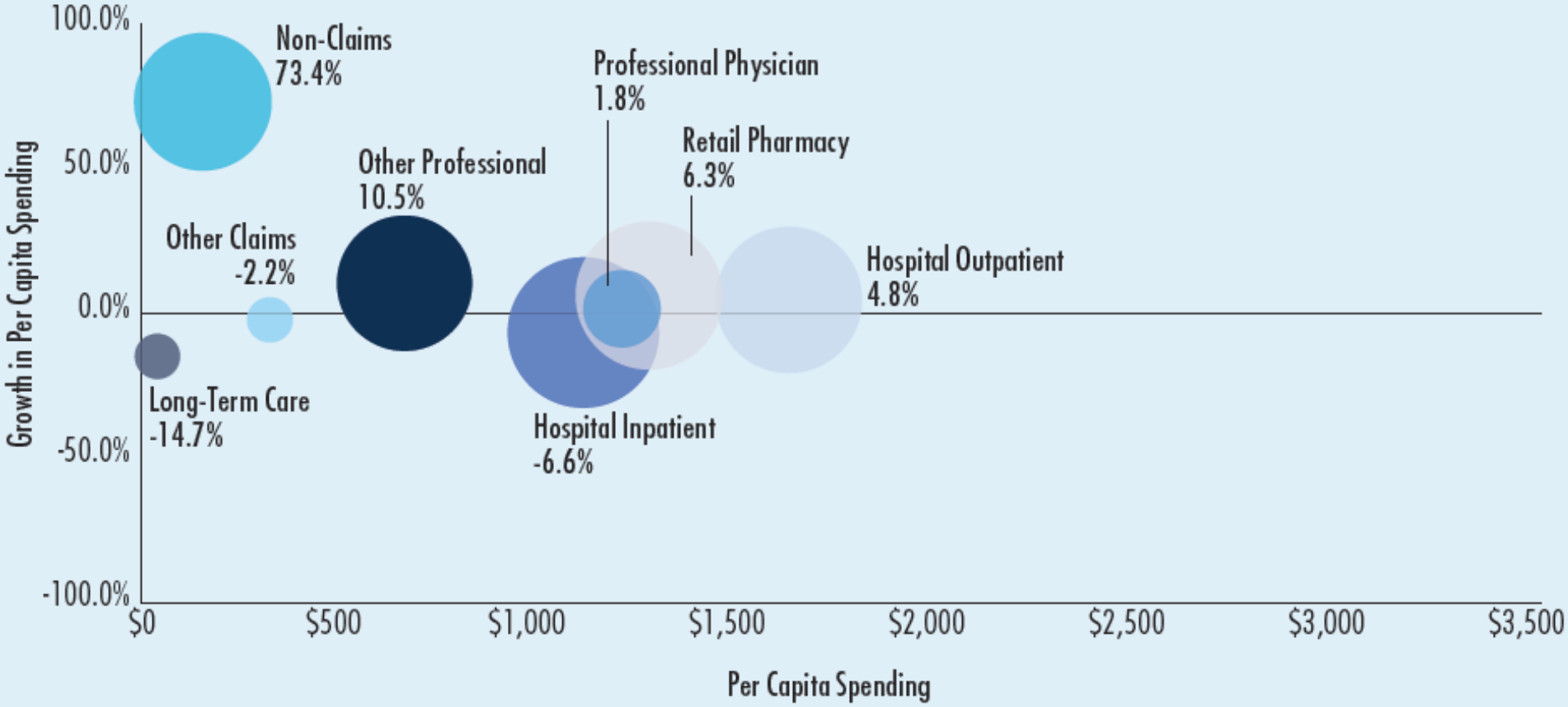
Service Category Trends

2022 State-Level Spending Growth Was Driven by Hospital Outpatient and Long-Term Care



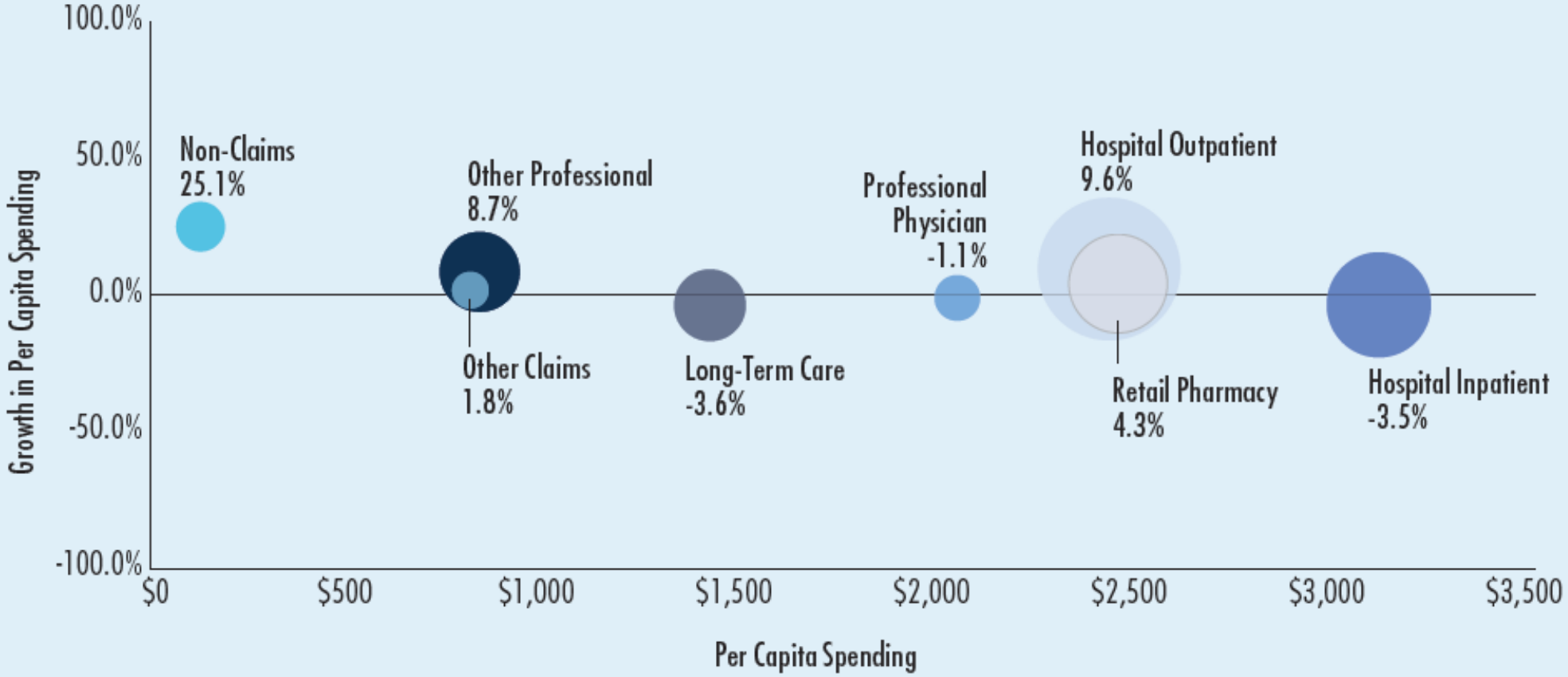
Source: OHIC analysis of TME data from insurers, CMS, and the Rhode Island EOHHS. Data are not risk-adjusted. Retail and medical pharmacy rebates are accounted for in the reporting of Retail Pharmacy spending. Data do not include NCPHI. The width of the bubbles represents contribution to growth.

Hospital Outpatient and Retail Pharmacy Drove Cost Growth in the Commercial Market in 2022



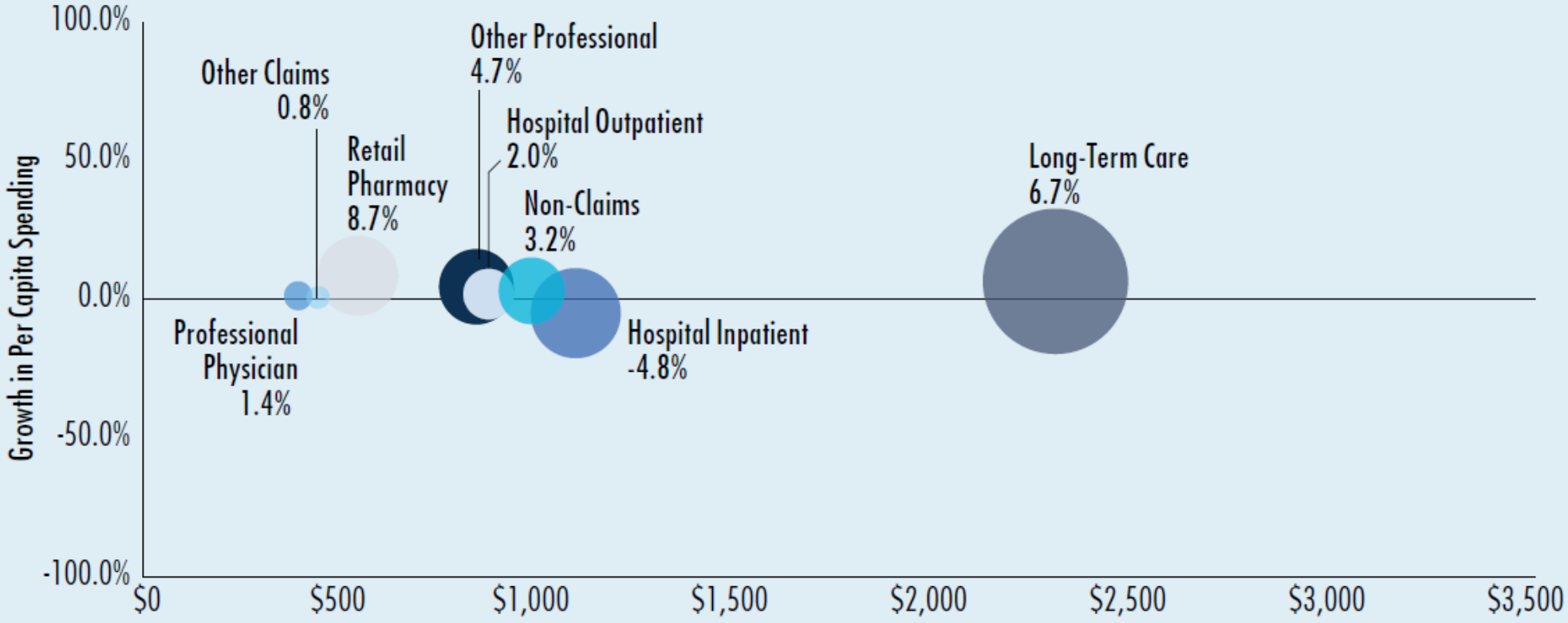
Source: OHIC analysis of TME data from insurers. Data are not risk-adjusted and are reported net of pharmacy rebates. The width of the bubbles represents contribution to spending growth.

Hospital Outpatient was the Primary Cost Growth Driver for the Medicare Market in 2022



Source: OHIC analysis of TME data from insurers. Data are not risk-adjusted and are reported net of pharmacy rebates. The width of the bubbles represents contribution to spending growth.

Long-Term Care Drove Cost Growth in the Medicaid Market in 2022



Source: OHIC analysis of TME data from insurers. Data are not risk-adjusted and are reported net of pharmacy rebates. The width of the bubbles represents contribution to spending growth.

Key Takeaways

There are a few main takeaways from these analyses:

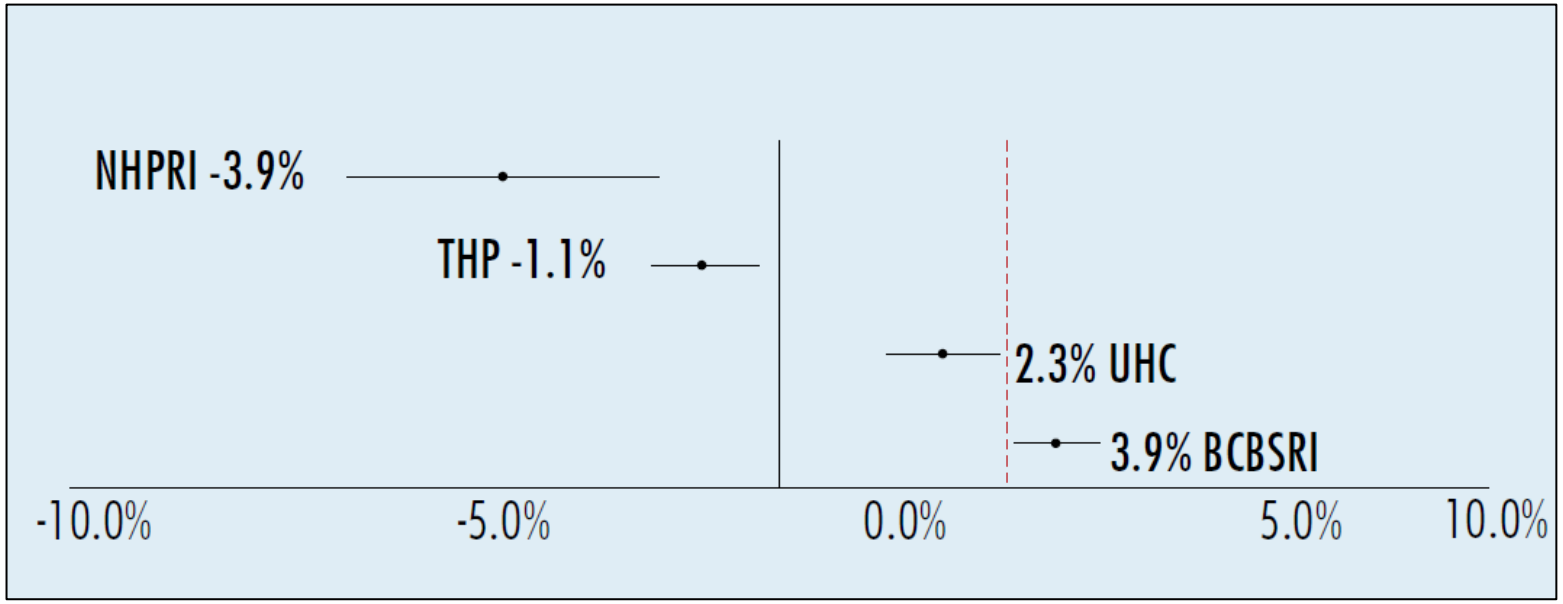
1. Statewide cost growth in 2022 was well **below** the State's target of 3.2 percent.
   - Even though the state met the target this year, spending is expected to increase substantially. This largely stems from the anticipated effect of **high inflation** during late 2022 and early 2023 on spending in 2023 and 2024.
2. At the state level**, Hospital Outpatient** drove spending growth in 2022. Other Professional spending growth was a more significant cost driver than it had been in previous years.
3. Retail Pharmacy **continued** to be a threat to health care affordability.
   - Growth in this service category **far exceeded** the cost growth target in each market (6.3, 4.3, and 8.7 percent in the commercial, Medicare and Medicaid markets, respectively).

Insurer Performance Against the Target

Commercial Insurers' Performance Against the Target

Target performance is calculated using Total Medical Expense data, after applying truncation and age/sex risk-adjustment.

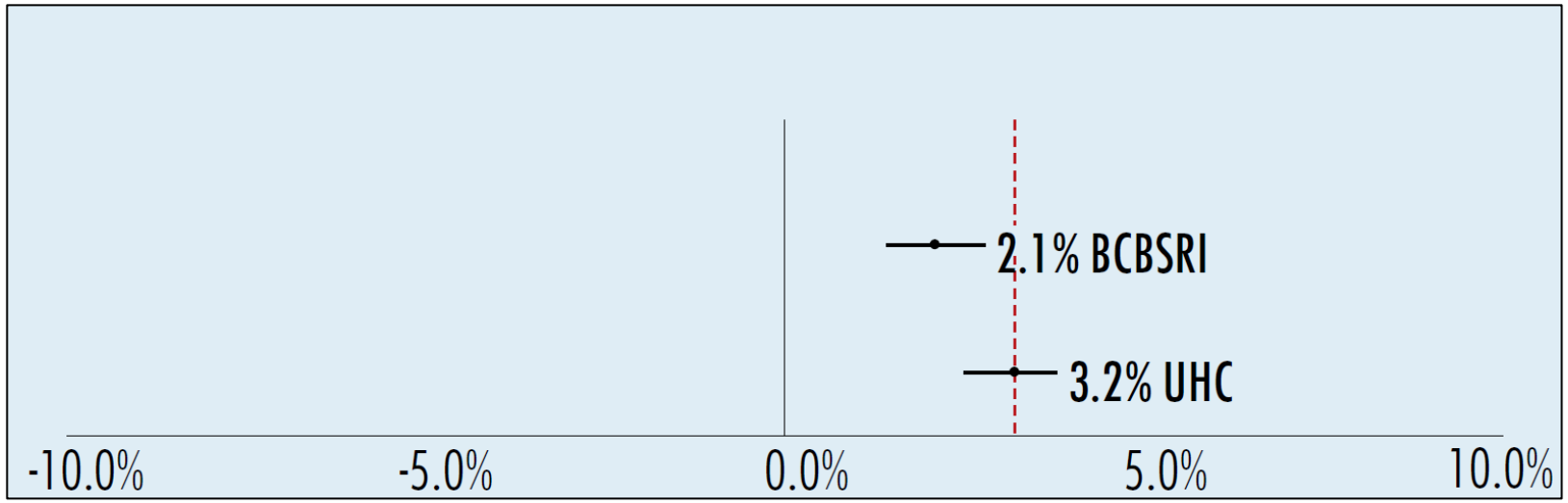
Data represent spending on fully insured and self-insured products, including the Federal Employee Health Benefits Program.



Payer	Target Performance
Blue Cross Blue Shield of RI	Did not meet the target
Neighborhood Health Plan of RI	Met the target
Tufts Health Plan	Met the target
UnitedHealthcare	Met the target

Medicare Advantage Insurers' Performance Against the Target

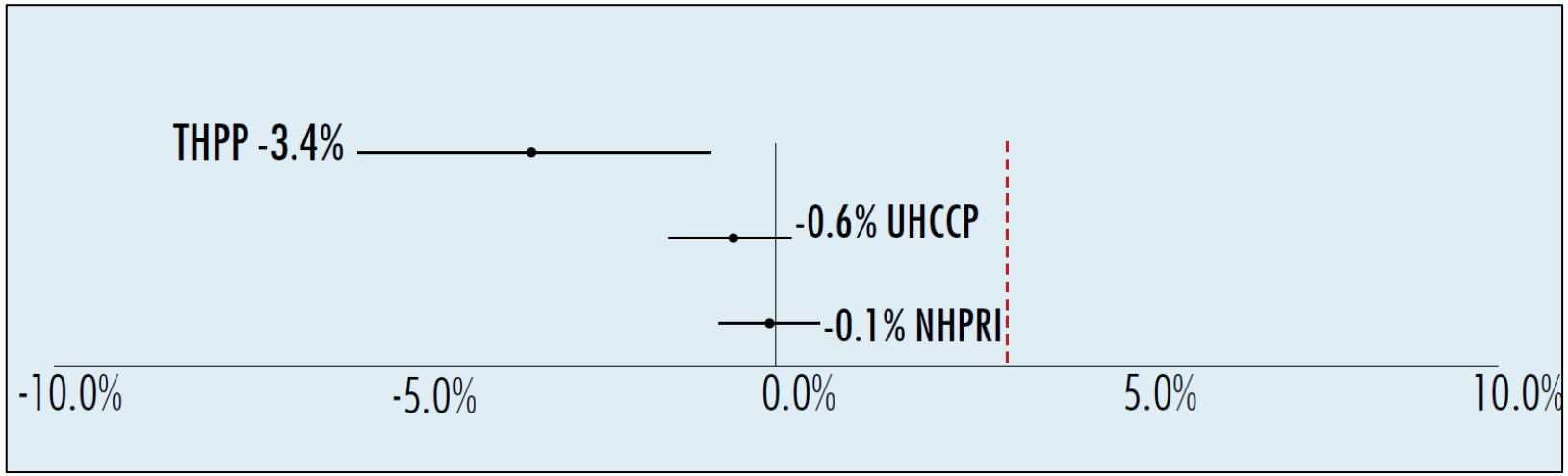
Target performance is calculated using Total Medical Expense data, after applying truncation and age/sex risk-adjustment.



Payer	Target Performance
Blue Cross Blue Shield of RI	Met the target
UnitedHealthcare	Unable to determine

Medicaid Insurers' Performance Against the Target

Target performance is calculated using Total Medical Expense data, after applying truncation and age/sex risk-adjustment.



Payer	Target Performance
Neighborhood Health Plan of RI	Met the target
Tufts Health Public Plans	Met the target
UnitedHealthcare	Met the target

Medicare-Medicaid Plans' Performance Against the Target

Target performance is calculated using Total Medical Expense 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.

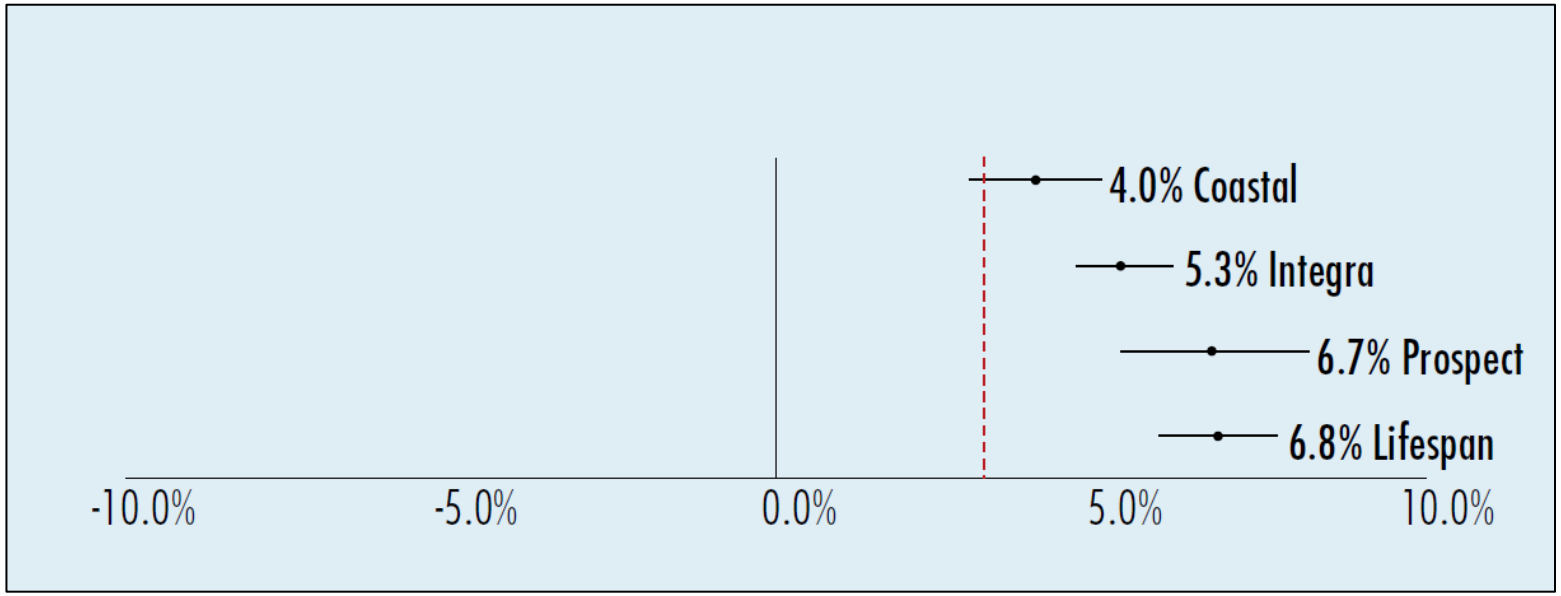
- Through CMS' Financial Alignment Initiative, Rhode Island has provided coverage to individuals who are dually eligible for Medicare and Medicaid through a combined Medicare-Medicaid Plan (MMP).
- NHPRI was the only insurer to offer such a product in 2022. For the 2022 performance period, NHPRI's MMP spending growth was 11.8 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. The increase in spending in 2022 for this population was primarily driven by an increase in members' home care spending and Hospital Outpatient spending.

Provider Performance Against the Target

ACOs' Commercial Performance Against the Target

Target performance is calculated using truncated and age/sex risk-adjusted spending.

2021-2022 commercial spending growth is not published for Blackstone Valley Community Health Care (BVCHC), Integrated Healthcare Partners (IHP), Providence Community Health Centers (PCHC), and Thundermist Health Center (THC) because they lacked enough commercial attributed lives to meet the minimum required for public reporting.

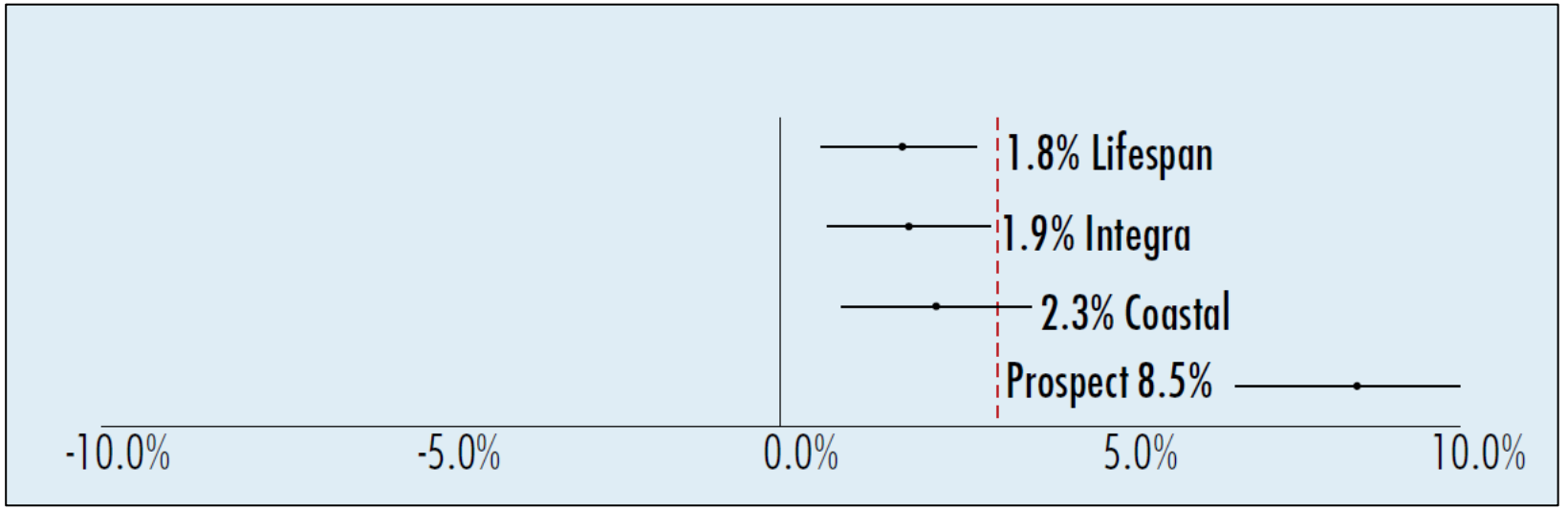


Payer	Target Performance
Coastal Medical	Unable to determine
Integra	Did not meet the target
Lifespan	Did not meet the target
Prospect CharterCARE	Did not meet the target

ACOs' Medicare Advantage Performance Against the Target

Target performance is calculated using truncated and age/sex risk-adjusted spending.

2021-2022 Medicare spending growth is not published for BVCHC, IHP, PCHC, and THC because they lacked enough commercial attributed lives to meet the minimum required for public reporting.

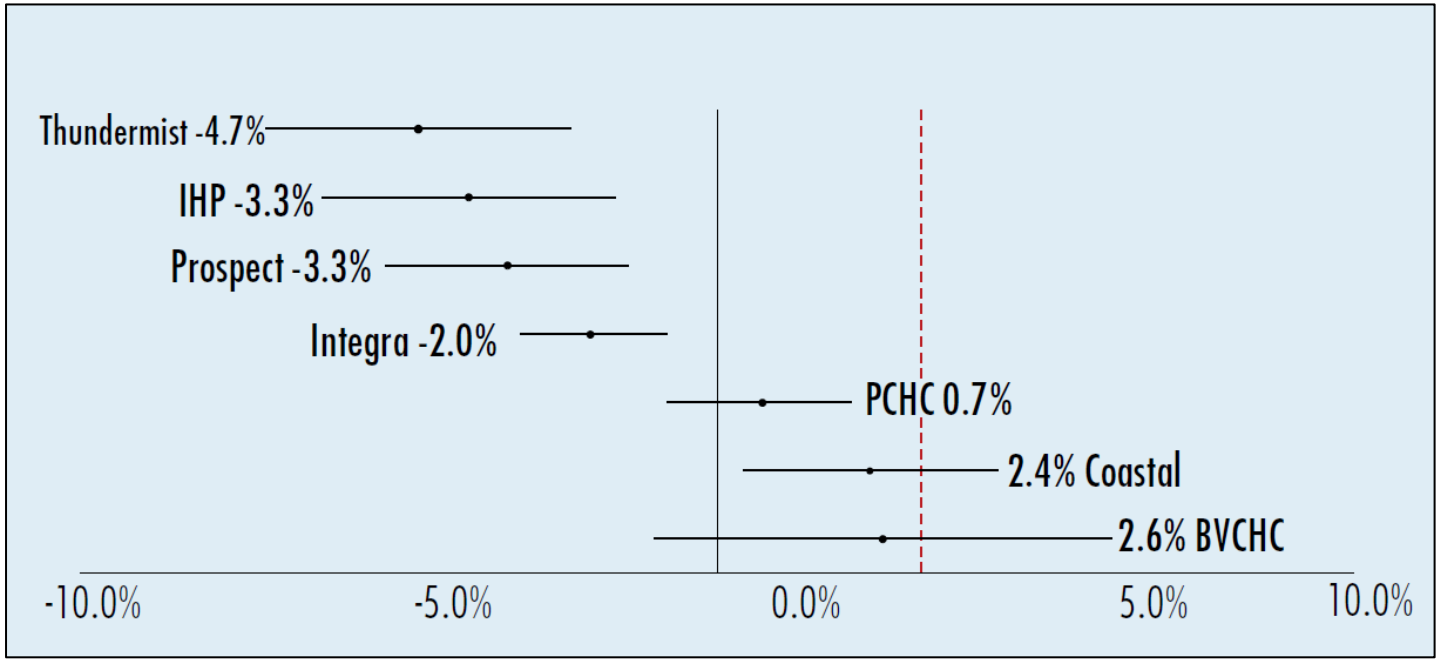


Payer	Target Performance
Coastal Medical	Unable to determine
Integra	Met the target
Lifespan	Met the target
Prospect CharterCARE	Did not meet the target

AEs' Medicaid Performance Against the Target

Target performance is calculated using truncated and age/sex risk-adjusted spending.

2021-2022 Medicaid spending growth is not presented for Lifespan because it did not have a Medicaid total cost of care contract with any Medicaid insurers.



Payer	Target Performance
Blackstone Valley Community Health Center	Unable to determine
Coastal Medical	Unable to determine
Integra	Met the benchmark
Integrated Healthcare Partners	Met the benchmark
Prospect CharterCARE	Met the benchmark
Providence CHCs	Met the benchmark
Thundermist Health Center	Met the benchmark

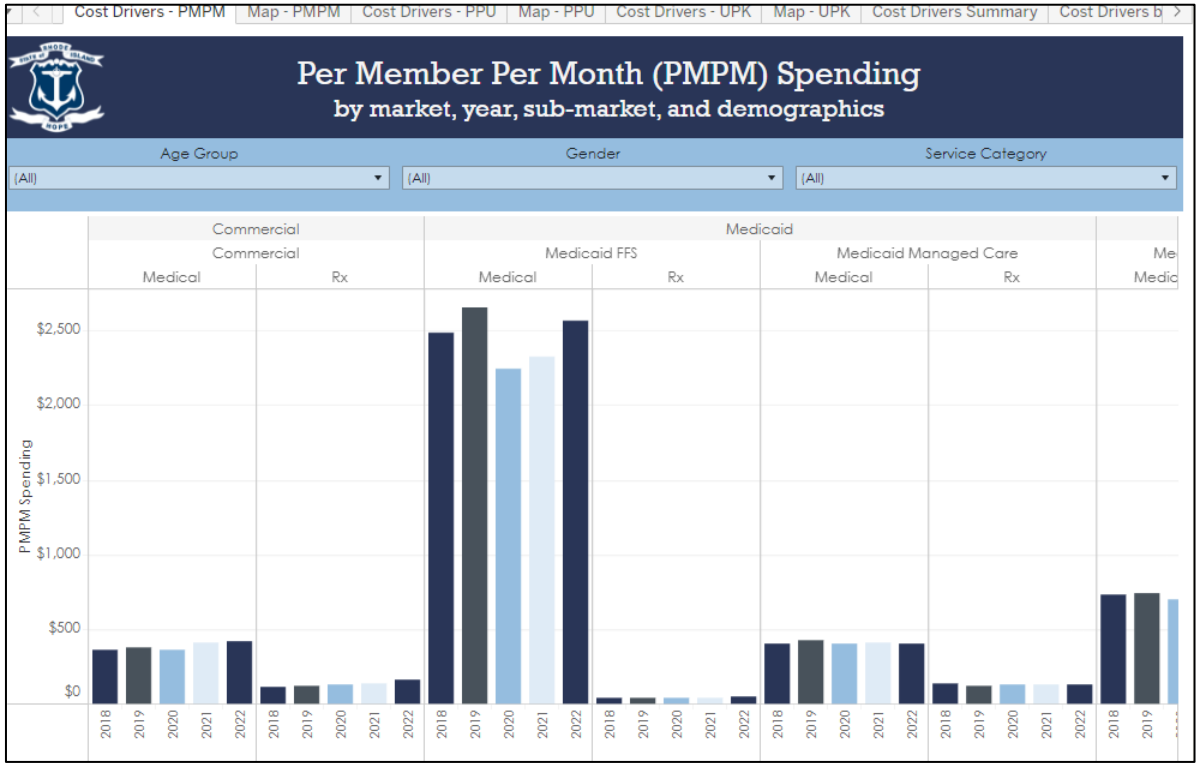
Cost Driver Analyses using the All-Payer Claims Database

Understanding Health Care Cost Growth Drivers

- According to cost growth target data, **Hospital Outpatient** and **Retail Pharmacy** were the primary cost drivers for the commercial market in 2022.
- The cost growth target data, however, do not allow for analysis of *why* these trends occurred.
- To gain this understanding, OHIC uses the more granular (i.e., claims-level) data that are available through the state's APCD.
- Last spring, OHIC made some of these data publicly available in the form of five public-facing, interactive dashboards on its Data Hub.

Examples from the OHIC Data Hub

- Each set of dashboards allows users to examine PMPM spending, unit payments, and utilization across the three markets. Users can also filter data by age and gender.



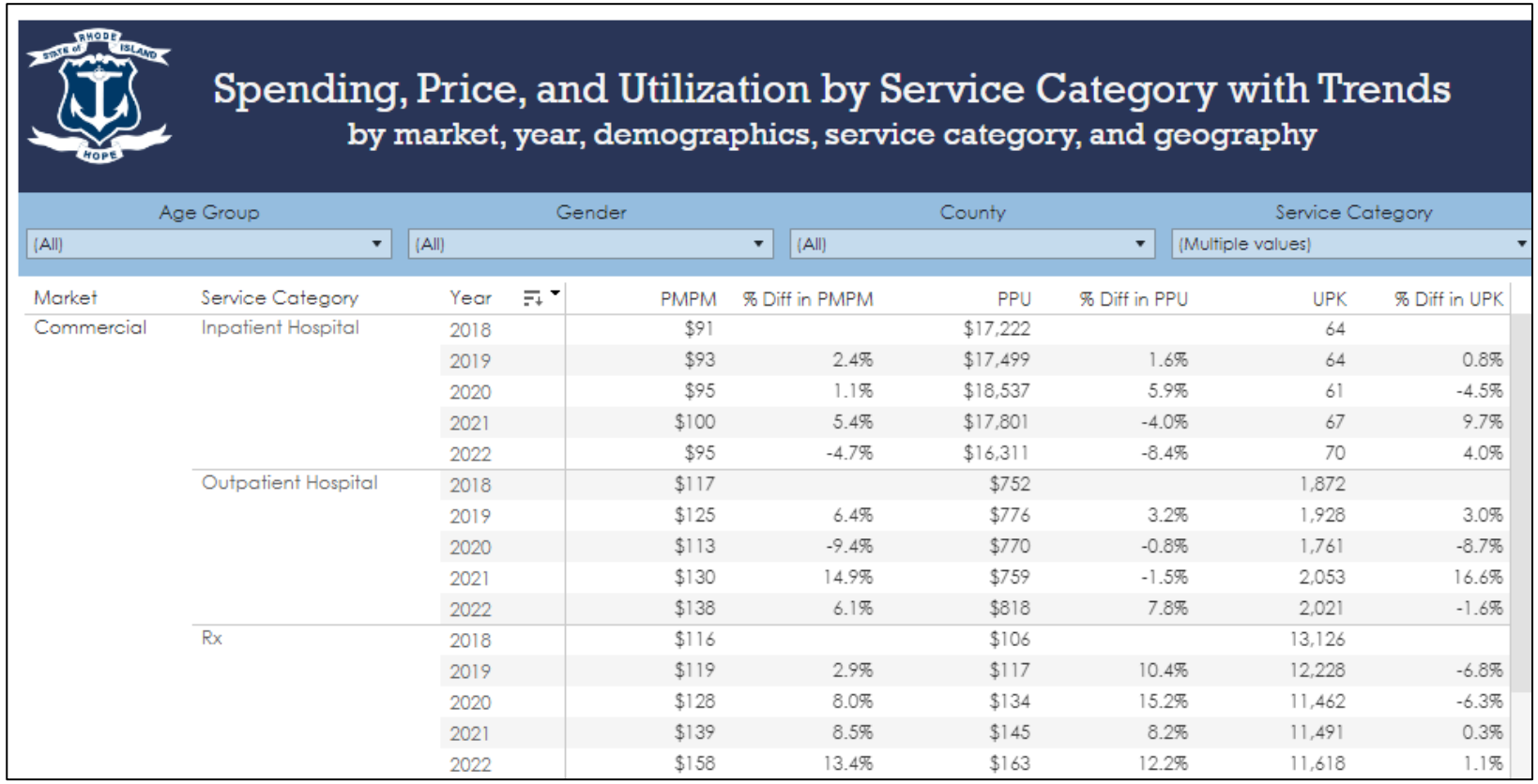
Example of the Cost Drivers: PMPM graph available in the 'Overview' dashboard

Understanding 2022 Commercial Market Cost Growth Drivers

- OHIC utilized these and other analytic tools to examine contributors to cost growth in the commercial market.
- The following slides provide the results of these analyses.
- As a reminder, analyses using APCD data are not directly comparable with analyses using cost growth target data.

Cost Trends Overview

- The first dashboard listed on the OHIC Data Hub is a 'Cost Trends Overview', which summarizes health care utilization and spending measures across RI.
- It displays spending per person (PMPM), payment per unit (PPU), and units per 1,000 members (UPK) by service category over a five-year period.



Spending, Price, and Utilization by Service Category with Trends

by market, year, demographics, service category, and geography

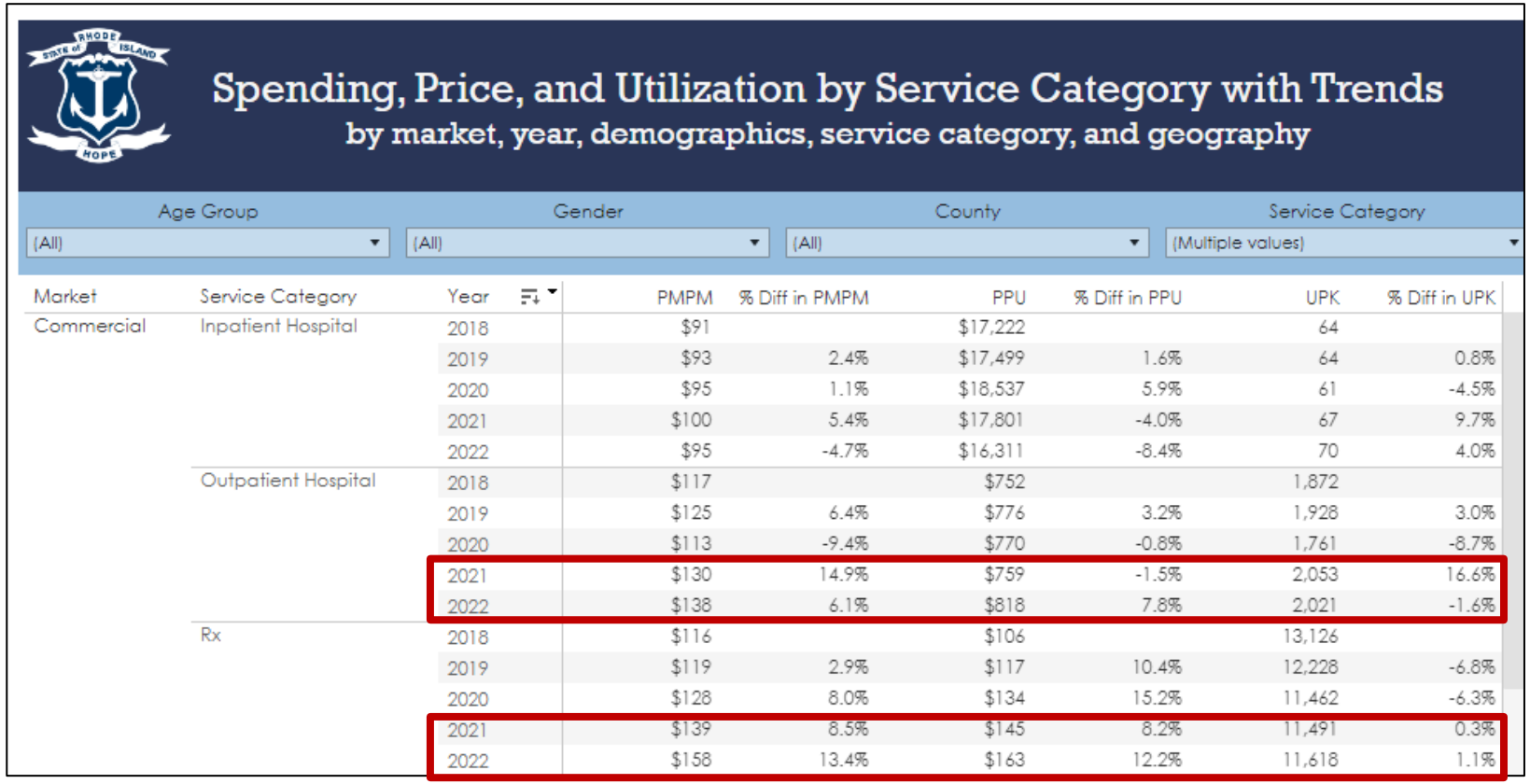
Age Group	Gender	County	Service Category
(All)	(All)	(All)	(Multiple values)

Market	Service Category	Year	PMPM	% Diff in PMPM	PPU	% Diff in PPU	UPK	% Diff in UPK
Commercial	Inpatient Hospital	2018	$91		$17,222		64	
		2019	$93	2.4%	$17,499	1.6%	64	0.8%
		2020	$95	1.1%	$18,537	5.9%	61	-4.5%
		2021	$100	5.4%	$17,801	-4.0%	67	9.7%
		2022	$95	-4.7%	$16,311	-8.4%	70	4.0%
	Outpatient Hospital	2018	$117		$752		1,872	
		2019	$125	6.4%	$776	3.2%	1,928	3.0%
		2020	$113	-9.4%	$770	-0.8%	1,761	-8.7%
		2021	$130	14.9%	$759	-1.5%	2,053	16.6%
		2022	$138	6.1%	$818	7.8%	2,021	-1.6%
	Rx	2018	$116		$106		13,126	
		2019	$119	2.9%	$117	10.4%	12,228	-6.8%
		2020	$128	8.0%	$134	15.2%	11,462	-6.3%
		2021	$139	8.5%	$145	8.2%	11,491	0.3%
		2022	$158	13.4%	$163	12.2%	11,618	1.1%

Note: Long-Term Care, Other Claims, and Professional services are also included in this dashboard view, but they have been omitted for this demonstration. Long-Term Care and Other Claims each represent a very small share of commercial spending.

Cost Growth Drivers for Outpatient Hospital and Retail Pharmacy

- Focusing on Outpatient Hospital and Retail Pharmacy, we see that **increases in payment per unit** was the driver of the spending growth for these categories in 2022.
  - Outpatient Hospital **PPU increased** nearly 8% while **UPK decreased** about 2%.
  - Retail Pharmacy **PPU increased** over 12% while **UPK increased** just 1%.



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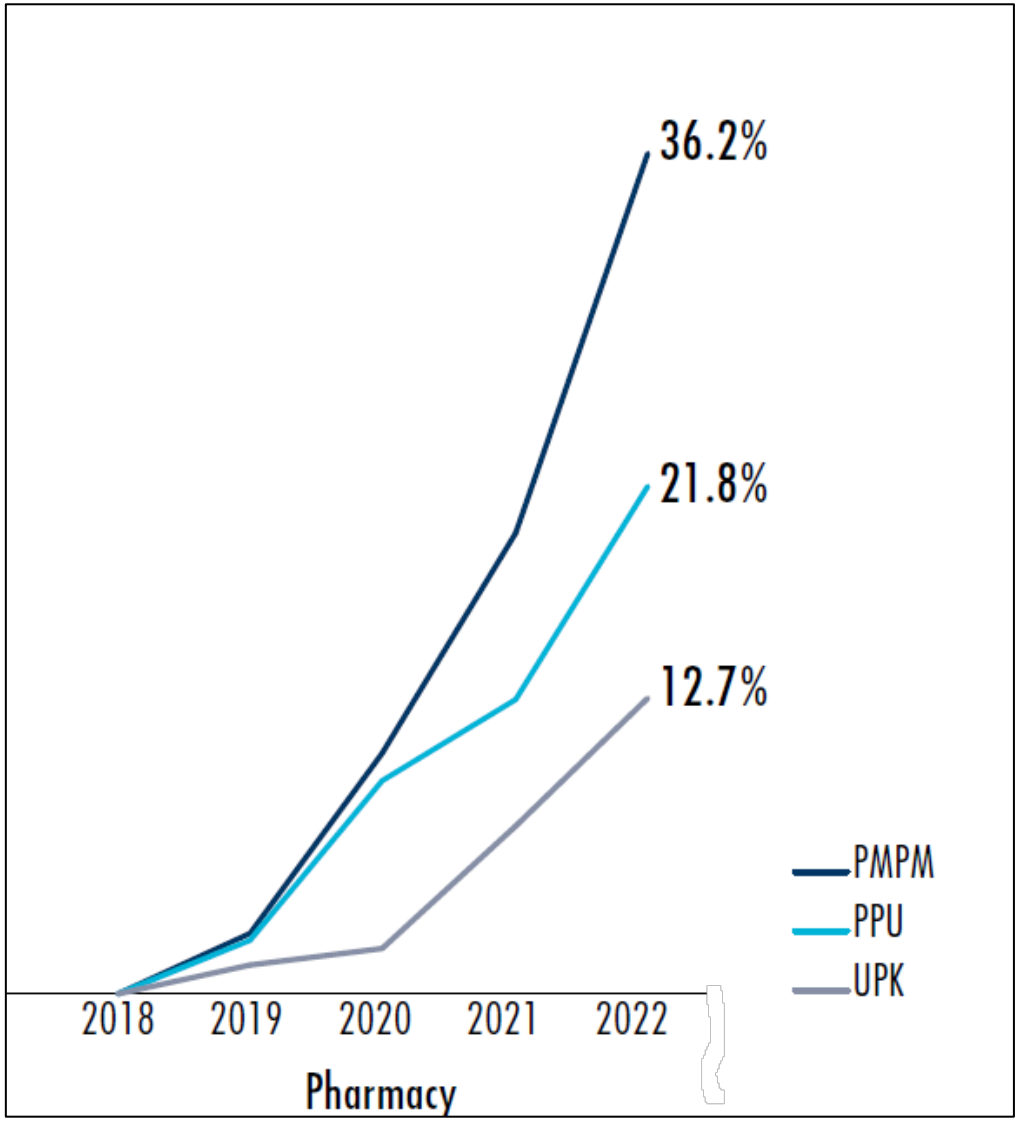
Retail Pharmacy: A Persistent Threat to Health Care Affordability

- The increase in unit payments for Retail Pharmacy services is not unique to 2022.
- Between 2018 and 2022, the growth in Retail Pharmacy spending was primarily driven by increases in unit payments.
  - Over this five-year period, Retail Pharmacy unit payments grew over 20 percent, at **an average of over five percent per year**.
  - Utilization, on the other hand, grew just under 13 percent in this time.

The introduction of costly drugs and gene therapies in the market will pose a challenge for the state to meet its cost growth target in the future.



What happened to Inpatient Hospital PPU?

- The Overview dashboard shows that unit payments for Inpatient Hospital **decreased** in 2022, but also in 2021.
  - This is very unusual - we expect PPU to increase every year across categories (as we see with Outpatient Hospital and Retail Pharmacy).
- To better understand the contributing factors to this decrease in Inpatient Hospital unit payments, OHIC conducted a "deep dive" analysis using APCD data.

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by market, year, demographics, service category, and geography

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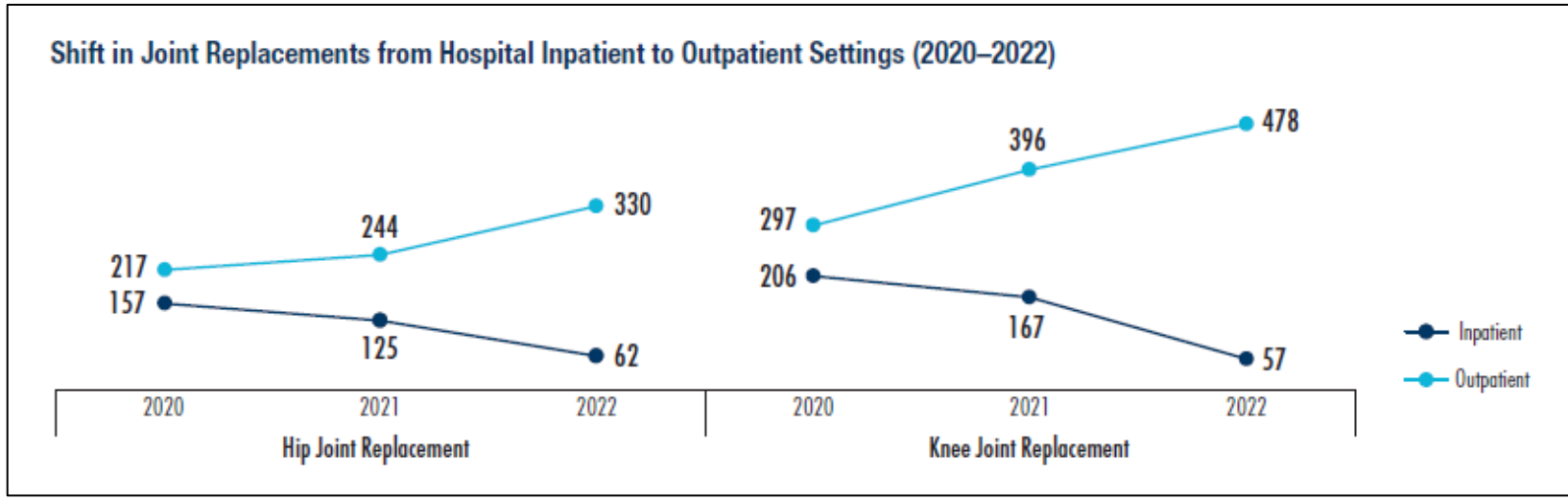
Note: Long-Term Care, Other Claims, and Retail Pharmacy are also included in this dashboard view, but they have been omitted for this demonstration. Long-Term Care and Other Claims each represent a very small share of commercial spending

Three Factors Contributed to the Decrease

- OHIC has identified three factors contributing to the decreases in Inpatient Hospital PPU in both 2021 (-4.0%) and 2022 (-8.4%):
  1) the movement of joint replacement surgeries from an inpatient to outpatient setting;
  2) decreases in admissions for major respiratory infections and inflammations, and
  3) decreases in utilization of tracheostomies and transplants.
- The following slides summarize OHIC's analysis on each of these drivers.

Driver #1: Movement of Joint Replacements from Inpatient to Outpatient Settings (1 of 2)

- Data from the APCD show that in 2021 and 2022, knee and hip replacements transitioned from being primarily performed in an inpatient hospital setting to being performed mostly in an outpatient hospital setting.
  - This was, in part, due to technological advancements and CMS rule changes.*

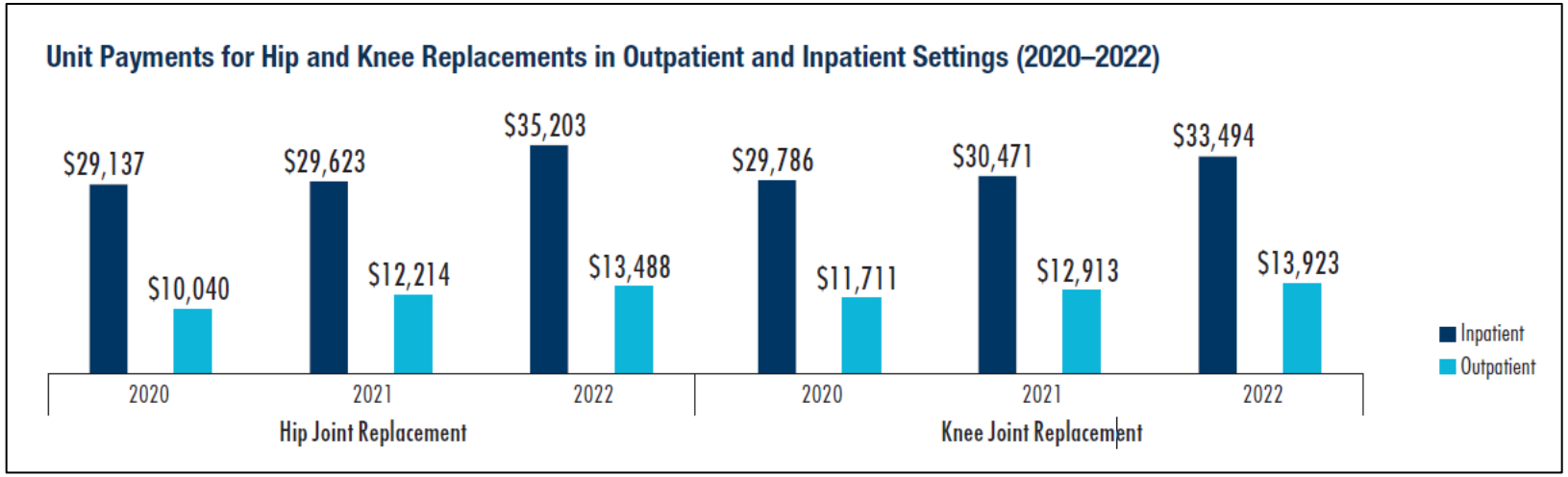


For both knee and hip replacements, the volume of inpatient units dropped dramatically from 2020 to 2022 (72 percent and 60 percent, respectively), and the volume of outpatient units increased substantially (60 percent and 52 percent, respectively).

*CMS removed total knee arthroplasty (TKA) from its inpatient-only list in early 2018, and total hip arthroplasty (THA) off this list in early 2020. These changes made these procedures reimbursable in hospital outpatient departments and ambulatory surgery centers. Although joint replacements had already been performed in outpatient settings prior to this change, this served as a signal from CMS that these procedures could be safely performed outside of a hospital inpatient room. For more information, see: https://www.arthroplastyjournal.org/action/showPdf?pii=S0883-5403%2823%2900070-0

Driver #1: Movement of Joint Replacements from Inpatient to Outpatient Settings (2 of 2)

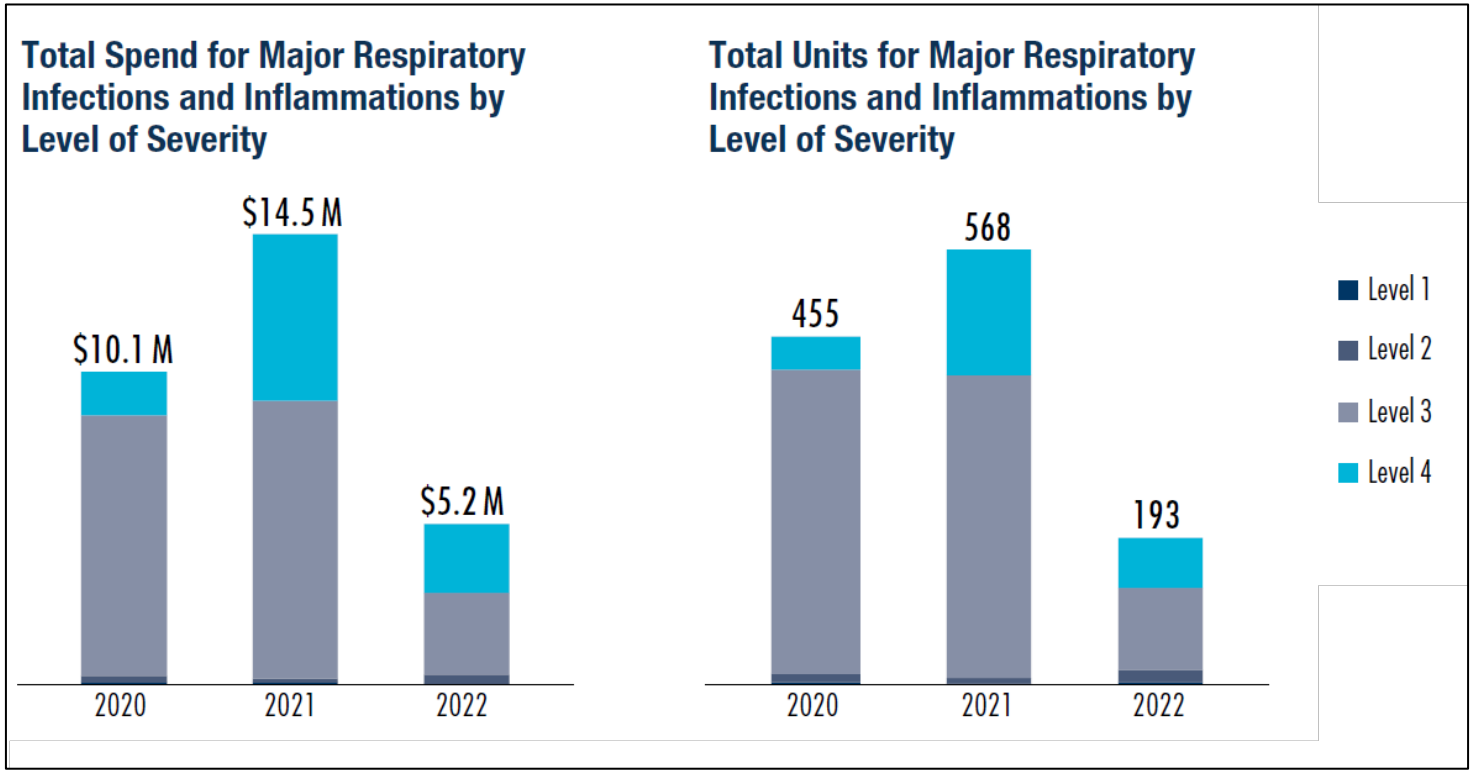
- The average unit payment for performing these surgeries in an outpatient setting is **significantly less** than performing them in an inpatient setting.



Unit payments for performing each of these procedures in an outpatient setting were about 40 percent that of their inpatient counterparts.

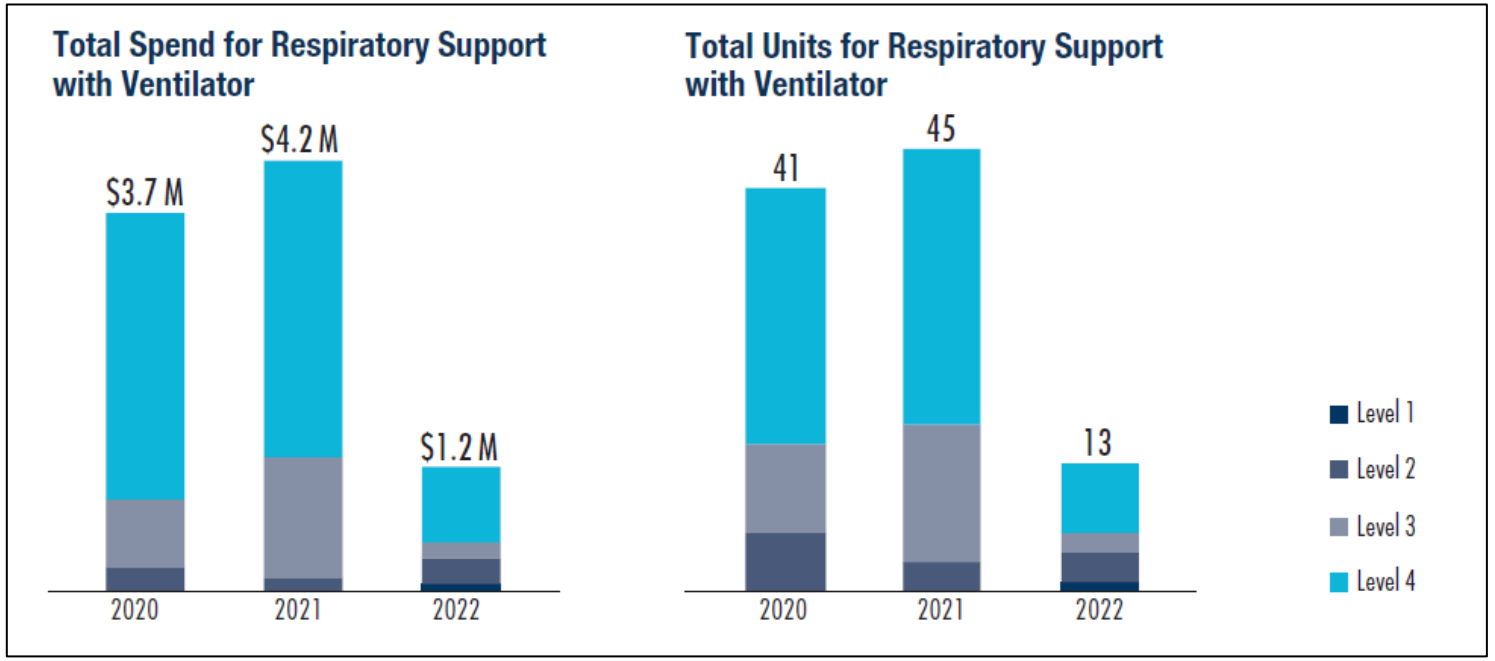
Driver #2: Decrease in Cases of Major Respiratory Infections and Inflammations

- Another factor that influenced the decrease in Inpatient Hospital PPU was the decrease in respiratory-related admissions.
  - Two conditions that that likely impacted overall inpatient hospital unit payments were 1) major respiratory infections and inflammations (which include COVID-19 cases), and…



Driver #2: Decrease in Cases of Major Respiratory Infections and Inflammations

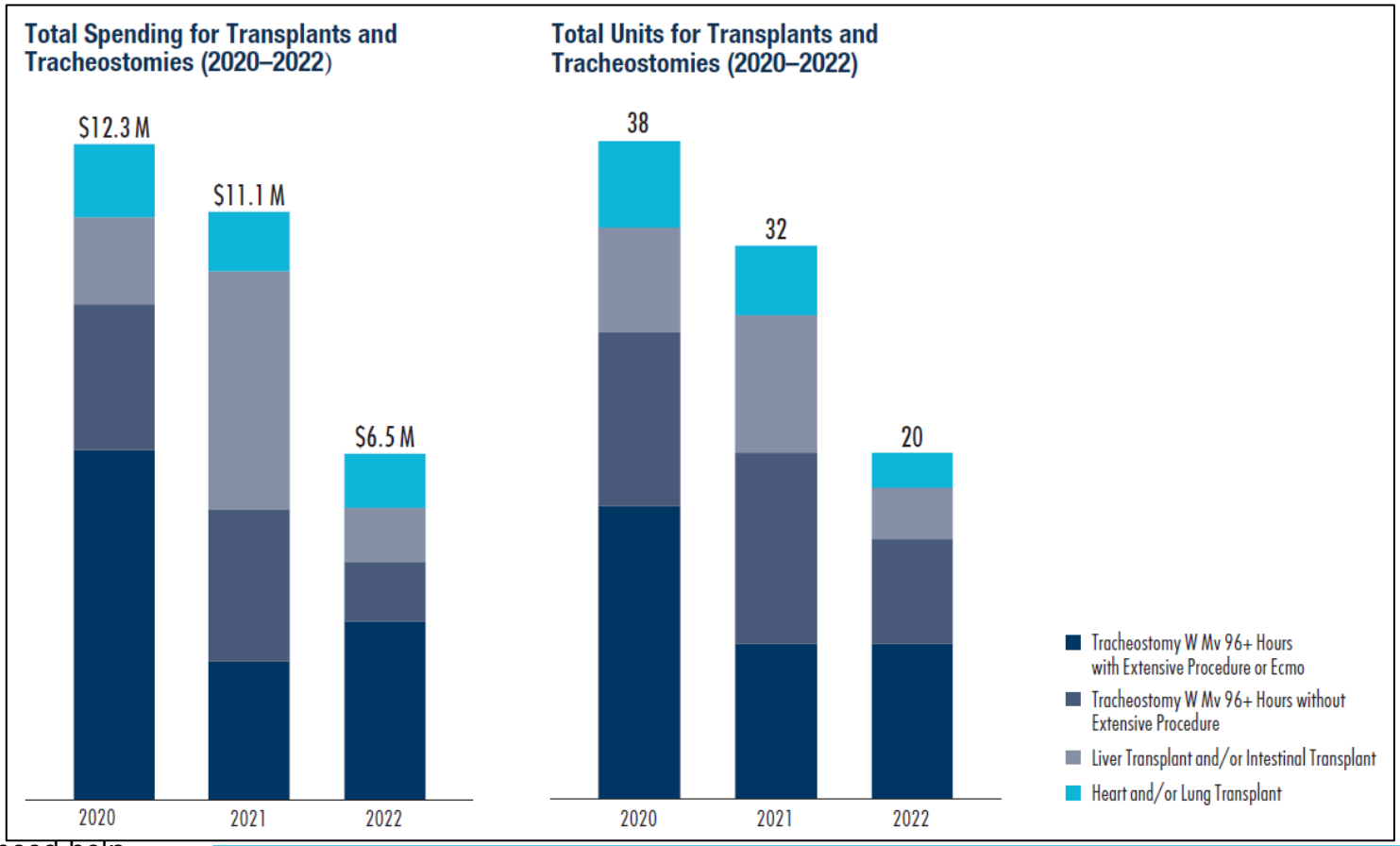
- …2) respiratory support with use of ventilators.



Unlike the prior two services, spending and units on these respiratory conditions increased in 2021, but then plummeted in 2022. This is expected, as it likely reflects lower prevalence of severe illness from COVID-19 (given that cases were less severe), as the population increasingly became vaccinated in 2022 or developed immunity to the coronavirus from prior infection.

Driver #3: Decrease in Utilization of High-Cost Services: Organ Transplants and Tracheostomies

- A third contributing factor to the decrease in Inpatient Hospital PPU was the decrease in utilization of two high-cost services, organ transplants and tracheostomies*. Unit payments for these services **exceeded $200,000**.



*Some individuals who become seriously ill with COVID-19 may need help breathing using a ventilator. A tracheostomy, where a surgeon inserts a breathing tube directly into a patient's trachea, can be used when an individual needs a ventilator for an extended period. Similarly, severe cases of COVID-19 may result in serious conditions for which lung transplantation is the only viable treatment.

Spending and units decreased in 2021, then more dramatically so in 2022. The declines in spending and utilization for tracheostomies is likely associated in part with the decline in COVID-19 admissions.

Summary

- Increases in **unit payments** were the primary drivers of cost growth for both Hospital Outpatient and Retail Pharmacy.
- There are three factors identified that influenced the decrease in Inpatient Hospital PPU in 2021 and 2022.
- OHIC can now perform these detailed analyses to identify contributors to trends observed at the higher-level service categories (e.g., Outpatient Hospital, Inpatient Hospital, and Retail Pharmacy).
  - OHIC could also perform similar analyses to understand changes in utilization for each of the service categories, as it has already done using the publicly available "Mental Health" dashboard.*

*OHIC recently published a data story that featured its analysis of professional spending related to mental health services. For more information, see: https://ohic.ri.gov/sites/g/files/xkgbur736/files/2024-03/RI%20OHIC%20March%20Data%20Story%20Mental%20Health.pdf.

More to Come

- OHIC will soon release five additional dashboards on its Data Hub:
  - Care Migration for Outpatient Chemotherapy,
  - Care Migration for Inpatient Admissions,
  - Chronic Conditions,
  - Emergency Department Visits by Severity, and
  - Inpatient Trend by Diagnosis Related Group (DRG).
- Members of the public are encouraged to utilize these tools to derive their own insights from health care spending data in Rhode Island.

Statewide and Market-Level Quality Performance

Quality Performance Background

- OHIC reports health care quality data to complement public reporting of spending growth and offer a balanced perspective on health system performance.
- OHIC reports on commercial and Medicaid quality performance for the Core Measures in OHIC's ACO Aligned Measure Set. This year's report contains calendar year 2022 performance.

What is the ACO Aligned Measure Set?

OHIC maintains common sets of quality measures ("Aligned Measure Sets") for use in contracts between insurers and providers. OHIC requires commercial plans to adhere to these aligned measure sets for use in primary care, ACO, acute care hospital, behavioral health hospital and outpatient behavioral health contracts. "Core Measures" refer to the measures in the Aligned Measure Set that insurers must use in applicable provider contracts (as opposed to Menu Measures and Developmental Measures, which are optional for use).

ACO Aligned Measure Set Measures

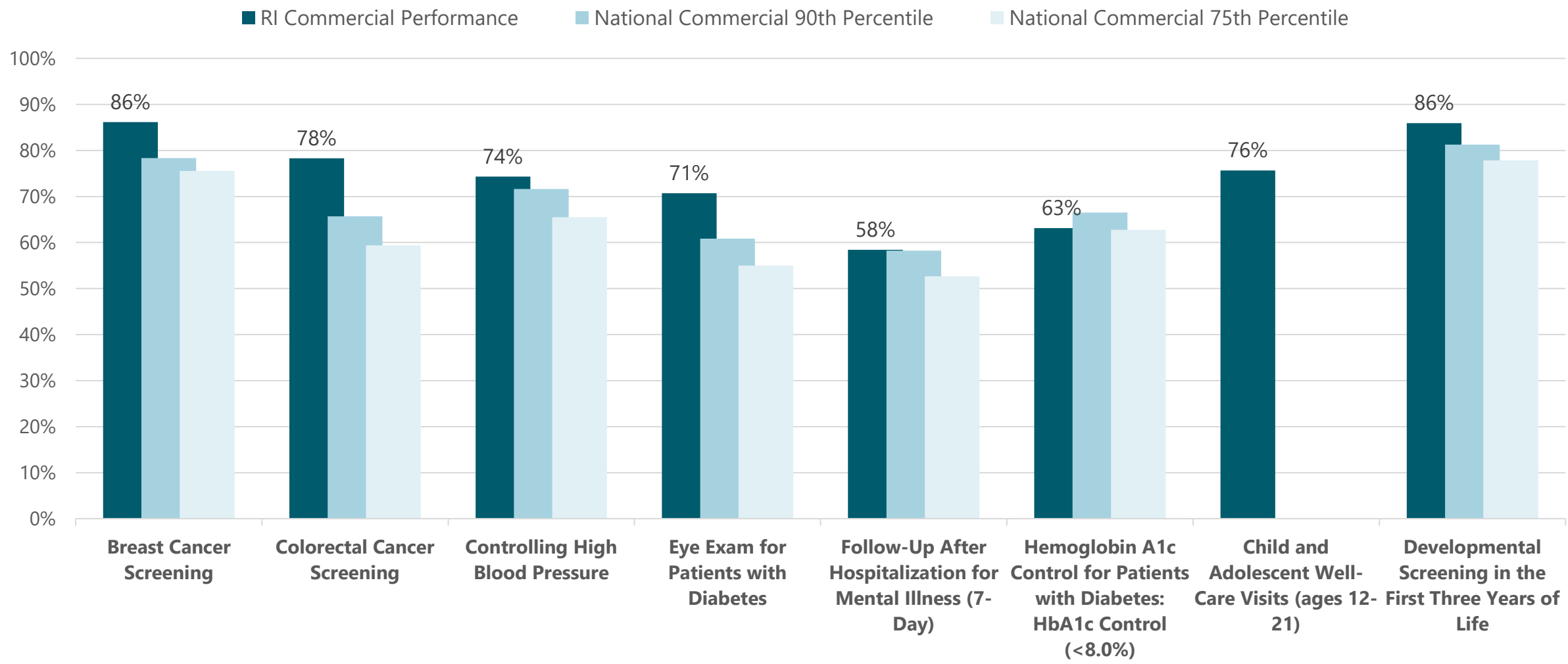
- The 2022 ACO Core Measure Set contained eight measures addressing chronic illness, behavioral health and preventive care:

1. *Breast Cancer Screening*
2. *Colorectal Cancer Screening*
3. *Eye Exam for Patients with Diabetes*
4. *Follow-Up After Hospitalization for Mental Illness (7-Day)*
5. *Hemoglobin A1c (HbA1c) Control for Patients with Diabetes: HbA1c Control (<8.0%)*
6. *Child and Adolescent Well-Care Visits (ages 12-21)*
7. *Developmental Screening in the First Three Years of Life*

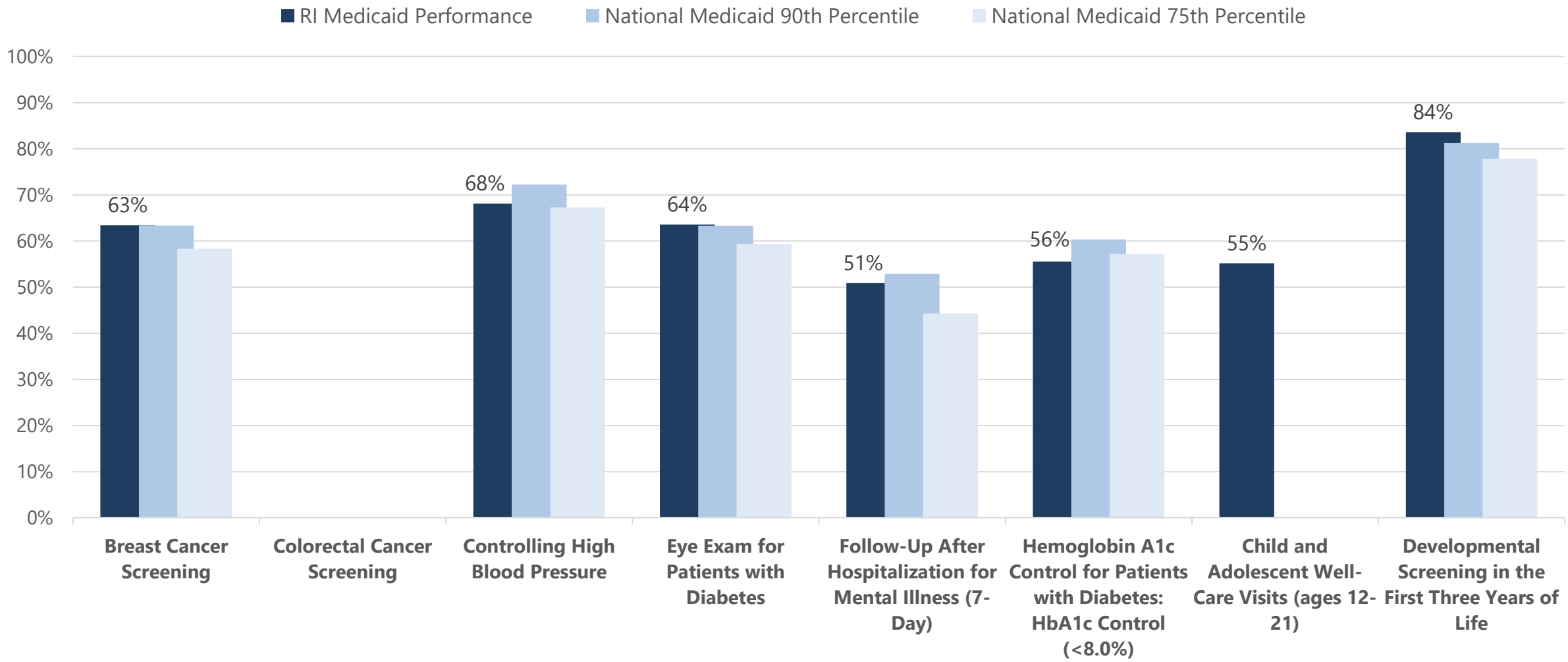
Data Collection and Analysis Methodology

Market	Data Source	Methodological Summary
Commercial	OHIC obtained commercial performance **directly from insurers** as part of the cost growth target data collection.	Statewide commercial performance is based on a **weighted average of insurer performance** because multiple insurers submitted measurement data using population samples.
Medicaid	**EOHHS** provided the data to calculate Medicaid performance, which it already collects as part of measurement and reporting of AE quality performance on the Medicaid **AE Common Measure Slate**.	Medicaid performance represents the **full population** for the measures because EOHHS requires that insurers submit performance data for their full population.

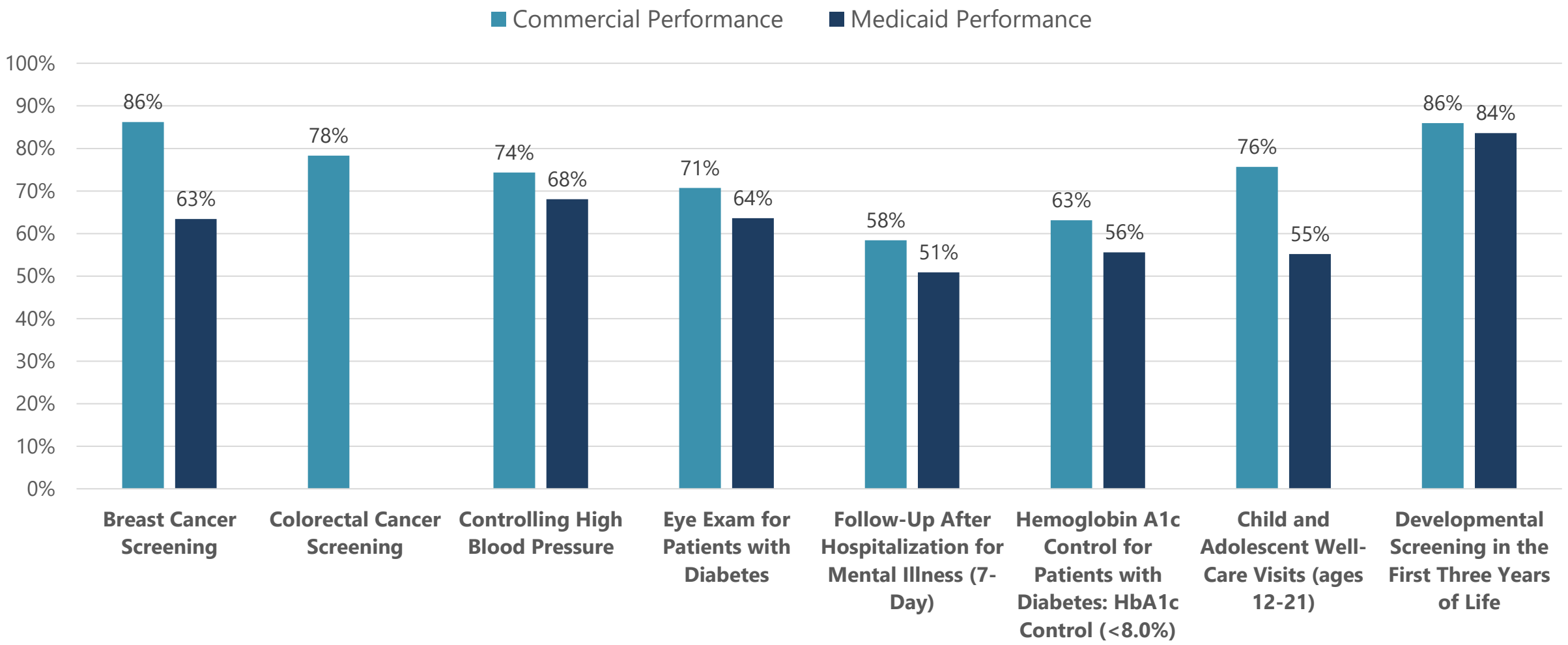
2022 Statewide Commercial Performance on the ACO Core Measure Set



2022 Statewide Medicaid Performance on the ACO Core Measure Set



2022 Statewide Medicaid and Commercial Performance on the ACO Core Measure Set



Baseline Performance on Public Health & Health Equity Measures

Public Health and Health Equity Measures Background

- The Rhode Island Cost Trends Steering Committee recommended that OHIC select a set of public health and health equity accountability measures with associated improvement goals to be reported publicly.
- In 2023, OHIC convened a Public Health and Health Equity Target Measures Work Group to recommend measures and targets.
- The Work Group recommended six measures, each with either a 2027 total population target or target focused on reducing a significant inequity in performance.
  - The Cost Trends Steering adopted the recommendations in late 2023.

Public Health & Health Equity Measure Set and Data Sources

- The Public Health and Health Equity Measure Set contains six measures addressing four domains: childhood obesity, behavioral health, health care access and maternal and infant health.

Measure Name	Data Source
Adults without a Usual Source of Care	Behavioral Health Risk Factor Surveillance System data, RI Foundation
Childhood Obesity Rate	BMI clinical and billing records, RI KIDS COUNT
Fatal Overdoses	CDC State Unintentional Drug Overdoses Reporting System
Inadequate Prenatal Care	Vital Records Birth Certificate data, RI Department of Health
Infant Mortality Rate	Vital Records Birth Certificate data, RI Department of Health
Severe Maternal Morbidity	Hospital Discharge Data, RI Department of Health

Baseline Performance on the Public Health and Health Equity Measure Set

Measure	Population	Baseline Performance*	2027 Target
Adults without a Usual Source of Care	Hispanic adults	24% *Compared to 11.4% statewide*	<17%
Childhood Obesity Rate	Separate targets for Black and Hispanic children	Black children: 29% Hispanic children: 33% *Compared to 23% statewide*	Black children: <23% Hispanic children: <27%
Fatal Overdoses	Total population	39.8 deaths per 100,000 persons *Compared to 35.0 nationally*	<35.0 deaths per 100,000 persons
Inadequate Prenatal Care	Ages < 20 years	8.1% *Compared to 3.3% statewide*	<4.0%
Infant Mortality Rate	Combined target for Black and Hispanic mortality rate	7.7 deaths per 1,000 live births *Compared to 5.5 statewide*	<5.5 deaths per 1,000 live births
Severe Maternal Morbidity	Total population	86.2 per 10,000 delivery hospitalizations**	<75.0 per 10,000 delivery hospitalizations

*Baseline performance is for 2022 for Adults without a Usual Source of Care and Fatal Overdoses. Baseline performance is for 2021 for Childhood Obesity Rate. Baseline performance for Inadequate Prenatal Care, Infant Mortality and Severe Maternal Morbidity is measured using a five-year rate (2018–2022).
**A comparable national figure for Severe Maternal Morbidity is not available for this time period.

Public Health and Health Equity Strategies Work Group

- To meaningfully make progress in meeting the performance targets for the Public Health and Health Equity measures, OHIC has convened a Public Health and Health Equity Strategies Work Group.
- The work group's goal is to recommend to OHIC at least one actionable strategy to meet each of the six performance targets adopted by the Cost Trends Steering Committee, no later than mid-December of 2024, with the intention of implementation in 2025.

Q&A

Thank You

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