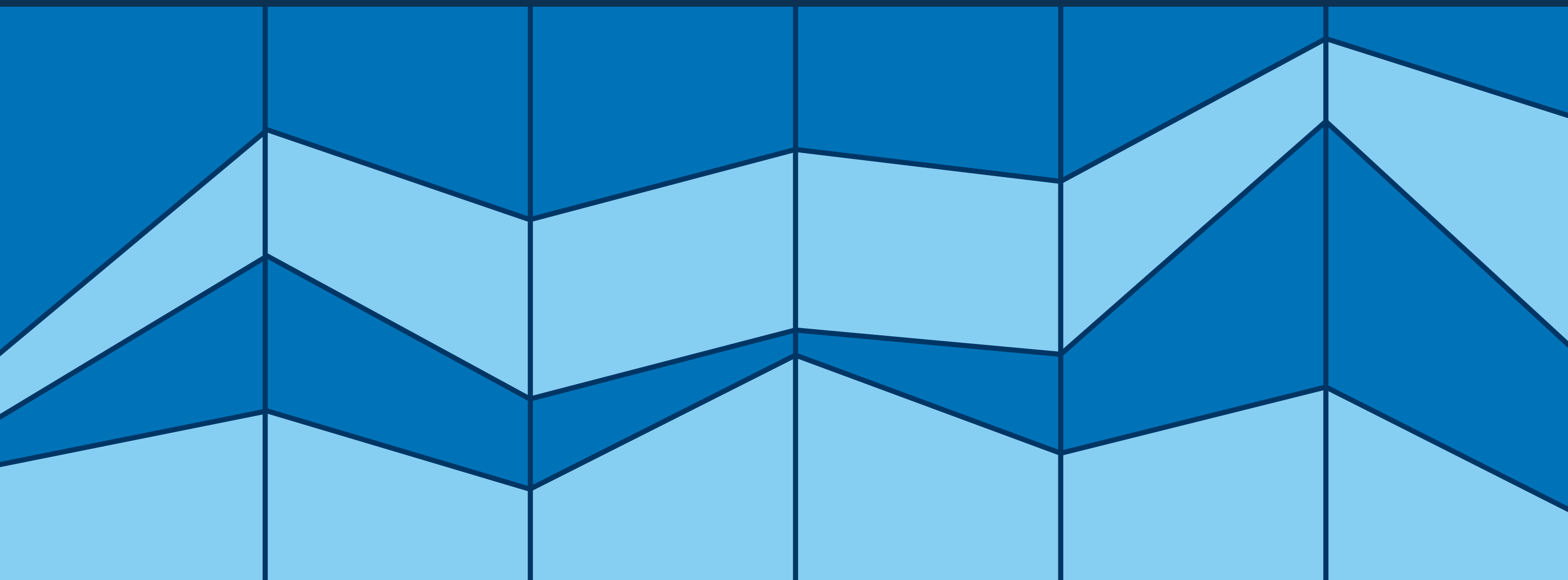
ANNUAL REPORT

Health Care Spending and Quality in Rhode Island

2024



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
EOHHS	Executive Office of Health and Human Services
IHP	Integrated Healthcare Partners
MEPS-IC	Medical Expenditure Panel Survey - Insurance Component
MMP	Medicare-Medicaid Plan
NA	Not Available
NCPHI	Net Cost of Private Health Insurance
NHE	National Health Expenditures
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
PPO	Preferred Provider Organization
RI	Rhode Island
RIDOH	Rhode Island Department of Health
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 (2024)

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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.

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Introduction

Statewide spending on health care for Rhode Islanders totaled nearly $9 billion in 2022. This spending constitutes a significant share of Rhode Island's economy, the state budget, employee compensation, and household expenses. The Office of the Health Insurance Commissioner (OHIC) measures health care spending growth and provides insights into the distribution and drivers of health care spending in the state. These insights are necessary for effective oversight of the health care system and to support shared accountability among insurers, providers and government for making health care affordable.

High and rising health care costs reduce available income for housing, education, and necessities. Health care spending growth forces tradeoffs for working Rhode Islanders and their families.

Nationally, health care spending is projected to grow 5.4 percent per year on average through 2031. This exceeds the projected average annual rate of economic growth.[1] Private health insurance expenditures per capita are projected to grow an average of 5.0 percent per year through 2031, compared to personal income per capita growth of 3.9 percent.[2] When health care spending growth outpaces growth in the economy and incomes, health insurance premiums and cost sharing increase, consuming a greater percentage of employee compensation and household expenses.

From 2001 to 2022, the average employer-sponsored family premium in Rhode Island increased from $8,023 to $22,955.[3] Over the same period, the average employee contribution to family premium increased from $1,703 to $6,290 and the average family deductible increased from $885 to $3,867.[4] The economics literature suggests that the growth of employer-sponsored health insurance premiums crowds out employee wage growth, in addition to shifting costs directly onto employees and their families.[5] This means that health care spending growth forces tradeoffs for working Rhode Islanders and their families because they rely on their wages to pay for housing, food, utilities, childcare, transportation, and to build their personal wealth.

Since 2019, health care leaders in Rhode Island, through the Cost Trends Steering Committee convened and co-chaired by the Health Insurance Commissioner, have voluntarily committed to keep health care spending growth below a Cost Growth Target that is tied to Rhode Island's projected rate of economic growth. Rhode Island's Cost Growth Target is modelled on the framework originally developed by Massachusetts policymakers. Adherence to a cost growth target does not mean that all health care spending growth should be reduced. In fact, there are components of Rhode Island's delivery system, such as primary care, community-based behavioral health care and Medicaid-funded community providers, where spending needs to grow to promote access to care in the most appropriate, lowest cost setting. Data analysis through OHIC's Health Spending Accountability and Transparency Program casts light on spending growth and opportunities for strategic investments in the health care delivery system.

1 Centers for Medicare & Medicaid Services (CMS), *NHE Fact Sheet*, accessed March 27, 2024, **https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/nhe-fact-sheet**.

2 Ibid. See: Downloads: NHE Projections – Tables. *Table01: National Health Expenditures and Selected Economic Indicator*, accessed March 27, 2024. Average growth rates are based on 2023–2031.

3 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 2022*, Medical Expenditure Panel Survey Insurance Component (MEPS-IC), accessed March 27, 2024, **https://datatools.ahrq.gov/meps-ic?tab=private-sector-state&dash=26**. Note that the MEPS-IC data includes self-insured employer data on "premium-equivalents" which are not directly comparable to fully insured premiums.

4 AHRQ, MEPS-IC.

5 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**. Also see: Hager K, Emanuel E, Mozaffarian D. *Employer-Sponsored Health Insurance Premium Cost Growth and Its Association With Earnings Inequality Among US Families*. JAMA Network Open. 2024;7(1):e2351644. doi:10.1001/jamanetworkopen.2023.51644.

This report presents the findings from analyses performed by OHIC to gain insight into the factors affecting health care spending growth in the state in 2022. Chapter 1 presents 2022 state and market level performance against the cost growth target. Chapter 2 reports on insurer performance against the cost growth target for each market and describes market-specific cost drivers. Chapter 3 showcases provider performance against the cost growth target by market. Chapter 4 examines Hospital Outpatient spending and utilization patterns based on analysis of the state's All-Payer Claims Database (APCD).[6] Chapter 5 describes the Rhode Island health care system's performance by state, market, and insurer on standard quality metrics and on public health and health equity measures. The report concludes with OHIC's recommendations on necessary steps to keep annual spending growth in Rhode Island below the target, while maintaining high standards for quality health care.

What is the Health Spending Accountability and Transparency Program?

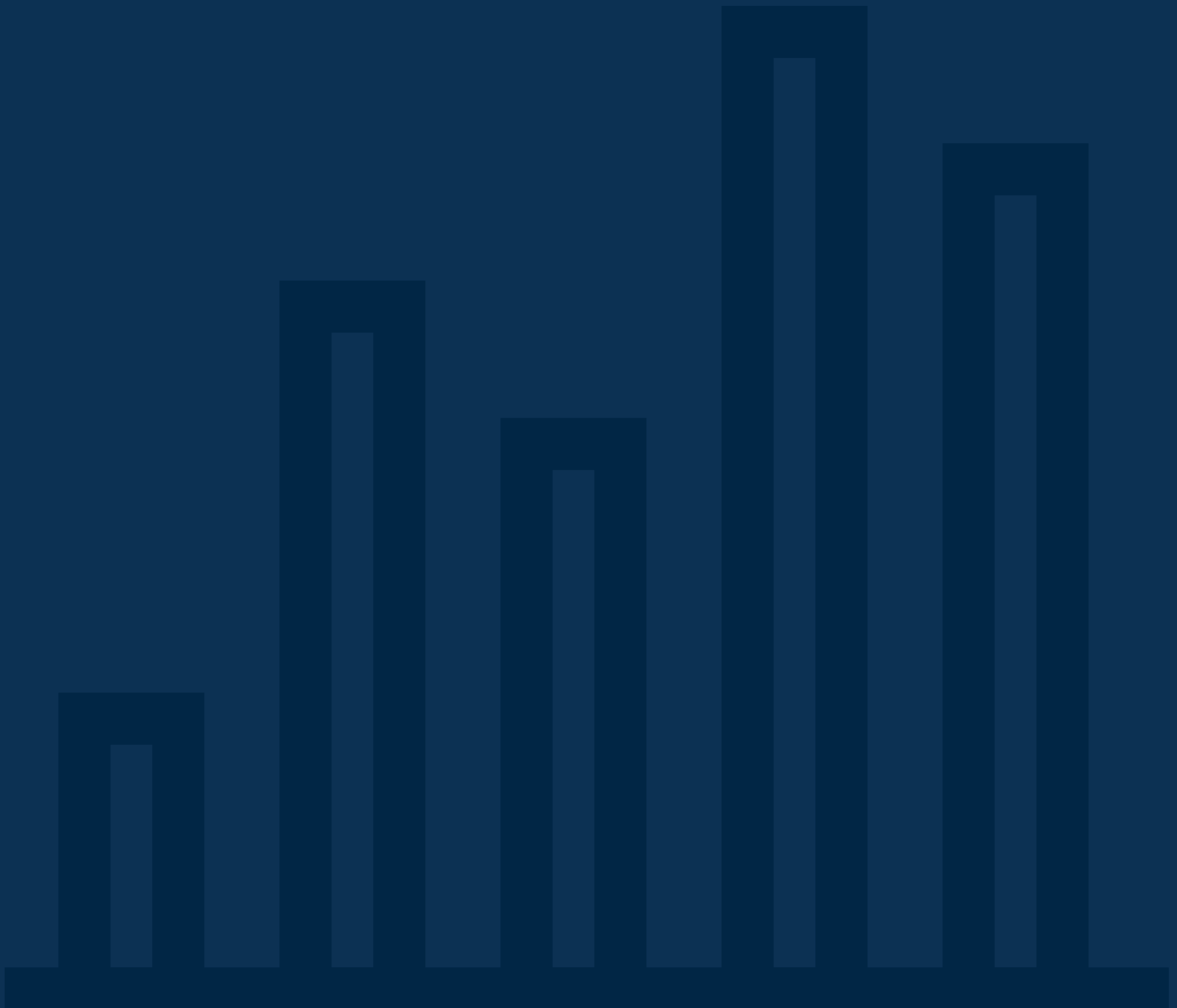
Rhode Island established the Health Spending Accountability and Transparency Program in July 2022 to strengthen accountability for health care spending and spending growth in the state. Informed by the work of the Rhode Island Health Care Cost Trends Steering Committee, the program seeks to achieve three key goals:

- Understand and create transparency around health care costs and the drivers of cost growth
- Foster collective accountability for health care spending and spending growth among key stakeholders by measuring performance against a spending growth target tied to economic indicators
- Mitigate the adverse effects of rising health care spending on Rhode Island residents, businesses, and government

6 This report analyzes data from both the cost growth target data collection and from the APCD. The differences between these two data sources are explained in the Appendix.

CHAPTER 1

Health Care Spending and Spending Growth in Rhode Island



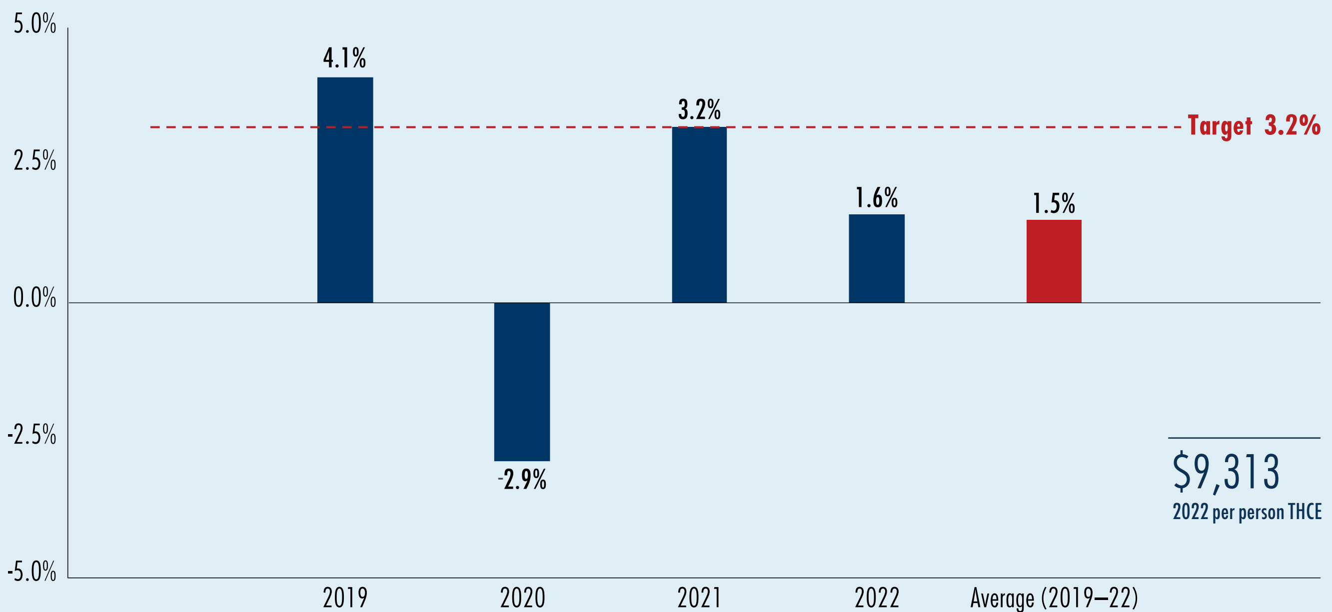
This is the fourth year that OHIC has analyzed health care spending growth since the Rhode Island Cost Trends Steering Committee set out to restrain health care spending growth through a voluntary compact in 2018. For 2019 to 2022 the state set an annual health care cost growth target of 3.2 percent, equivalent to the long-term forecasted growth in Rhode Island's Potential Gross State Product (PGSP). This chapter presents 2022 state and insurance market performance against the cost growth target, and 2022 health care spending patterns based on OHIC's annual Cost Trends data collection.[1]

The state met the cost growth target in 2022, owing largely to slowed spending on Hospital Inpatient and Professional Physician services.

Statewide Spending and Spending Growth

OHIC assesses statewide performance against the health care cost growth target by calculating the annual change in Total Health Care Expenditures (THCE). THCE represents all claims and non-claims payments to providers for covered services[2] (also referred to as Total Medical Expense, or TME) delivered to individuals who receive coverage through commercial insurance, Medicare, and Medicaid, as well as the cost of administering private health insurance (also known 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 with state and federal government data.

Exhibit 1.1: Statewide Performance Against the Cost Growth Target, 2019–2022



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), and publicly available insurer regulatory filings.

In 2022, statewide health care spending increased by 1.6 percent, well below the established target of 3.2 percent. State-level spending growth was lower in 2022 than in 2021 when patients began seeking care that they avoided in 2020 due to the pandemic. Average annual spending growth from 2019 through 2022 was 1.5 percent (see Exhibit 1.1). After a decrease in health care spending in 2020, spending growth remained low in 2021 and 2022 even as utilization patterns began to return to normal.

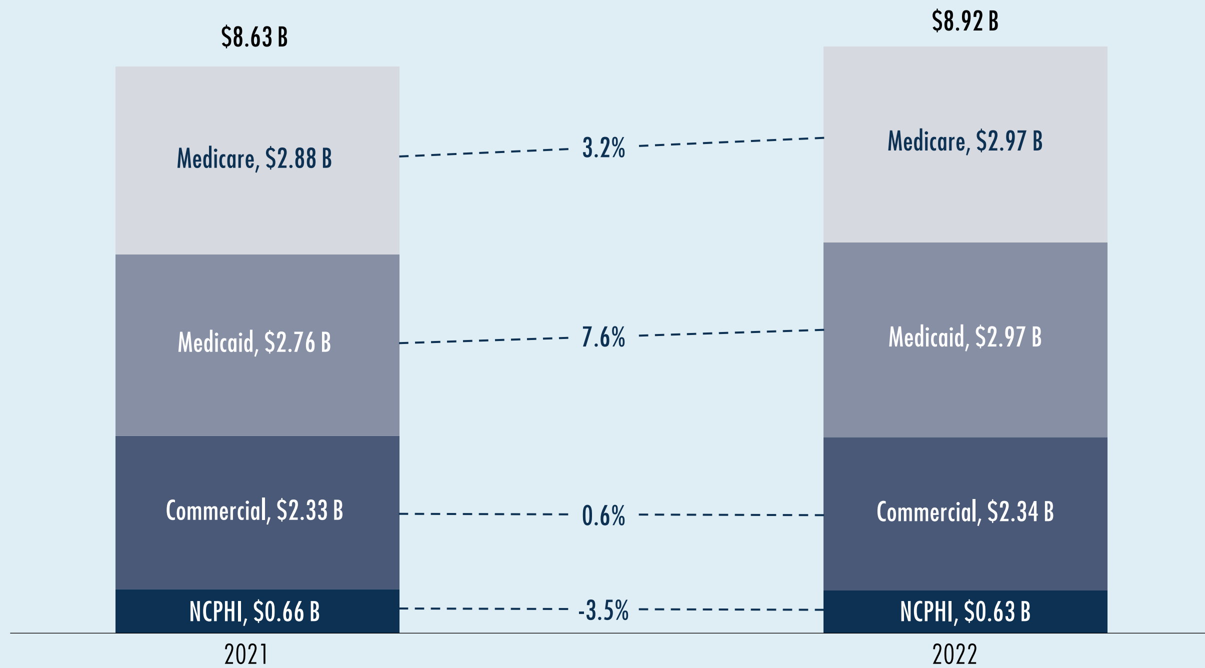
1 For details on the data collection and analysis methodology, see OHIC, *Rhode Island Health Care Cost Growth Target and Primary Care Spend Obligation Implementation Manual*, August 1, 2023, https://ohic.ri.gov/sites/g/files/xkgbur736/files/2023-08/RI%20TME%20%26%20PC%20Spend%20Implementation%20Manual_CY21-22%202023%2008-01_v1.pdf.

2 Some non-claims payments are not for covered services but are for incentives or infrastructure payments needed to support care delivery, e.g., electronic health record infrastructure payments.

Spending by THCE Component

In 2022, the state spent $8.92 billion on health care, representing an increase of 3.4% from 2021 spending levels. Commercial market spending made up 26 percent of total spending at $2.3 billion in 2022. Medicare and Medicaid each represented 33 percent of total spending, at $2.97 billion each. Private insurer administrative spending represented 7.6 percent of spending at $634 million (see Exhibit 1.2).

Exhibit 1.2: Aggregate Statewide Spending Growth by THCE Component, 2021–2022

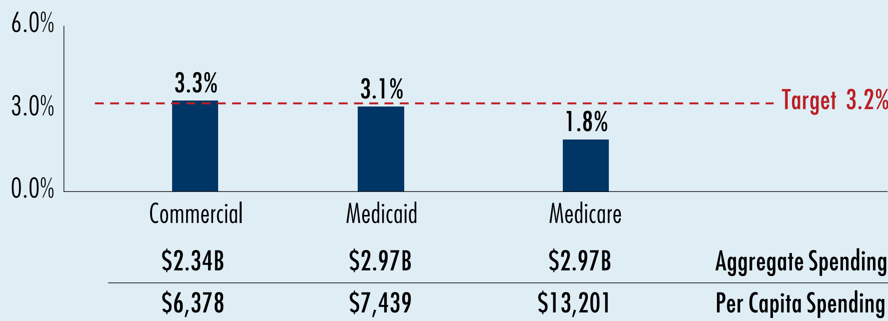


Source: OHIC analysis of TME data from insurers, CMS, the Rhode Island EOHHS, and publicly available insurer regulatory filings.

On a per capita basis, 2022 commercial market spending was $6,378, which represents a 3.3 percent increase over 2021 (see Exhibit 1.3). Some other states with cost growth targets saw similar growth in their per person commercial market spending.[3] Per capita spending on Medicare increased 1.8 percent to $13,201, while Medicaid spending increased 3.1 percent to $7,439. Per capita spending growth in Medicaid continued to be affected by the pandemic as the federal requirement to maintain continuous coverage during the coronavirus public health emergency persisted in 2022.

3 Connecticut's commercial per capita spending increased 2.4 percent in 2022. For more information, see: Connecticut Health Strategy, Healthcare Benchmark Initiative Steering Committee Minutes from March 25th meeting, March 25, 2024. https://portal.ct.gov/-/media/ohs/hbi-steering-committee/2024-meetings/march-25-2024/hcbi-steering-committee-meeting-21-2024-3-25.pdf
In 2022, Massachusetts' spending per person in the commercial market grew by 4.1 percent. For more information, see: Massachusetts Health Policy Commission, Hearing to Determine the 2025 Health Care Cost Growth Benchmark (slide 13), March 14, 2024. https://www.mass.gov/doc/presentation-2024-benchmark-hearing/download

Exhibit 1.3: Growth in Per Capita TME, by Market, 2021–2022[4]

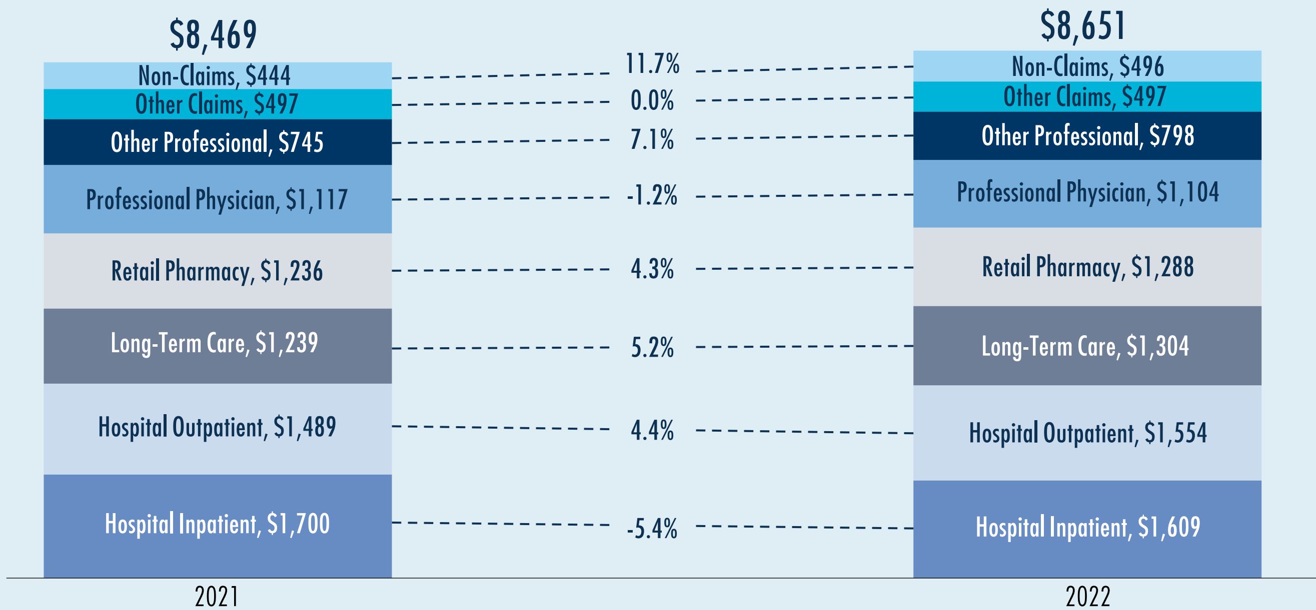


Source: OHIC analysis of TME data from insurers, CMS, and the Rhode Island EOHHS.

Statewide Spending Trends by Service Category

An analysis of spending by service categories in 2022 shows that per capita spending on Hospital Inpatient services and Professional Physician services statewide decreased, while spending on Other Claims remained constant and spending on all other service categories increased (see Exhibit 1.4). The decrease in Hospital Inpatient and Professional Physician services spending reflects some lower utilization of these services relative to 2021, when residents largely sought care after having delayed, avoided, or canceled it in 2020.[5] Hospital services made up the largest portion of

Exhibit 1.4: Per Capita TME by Service Category



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

4 Statewide THCE trend in 2022 was 1.6 percent, which is below that of each of the three markets shown here. THCE includes NCPHI, which decreased on a per person basis by five percent. 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.

5 OHIC's Data Hub displays interactive dashboards using data from the RI APCD. The dashboards show that there was decreased utilization of Professional and Hospital Inpatient services in 2022 for the Medicaid market, but not for the commercial market. OHIC currently cannot glean insight into Medicare spending for 2022 due to claims lag for these data. For more information, see: **https://ohic.ri.gov/data-reports/ohic-data-hub**.

health care spending, with Hospital Inpatient and Outpatient services comprising 37 percent of per capita TME. In 2022, per capita spending on Hospital Outpatient services increased over 4 percent, bringing it to a level that approaches spending for Hospital Inpatient services.

Service categories that experienced the largest growth were Non-Claims and Professional Other. The increase in Non-Claims payments was primarily driven by an increase in capitation and performance incentive payments to providers on a statewide basis. This increase also reflects additional Medicaid upper payment limit payments to hospitals, and its supplemental payments to providers in 2022. The increased spending on Professional Other services, which includes behavioral health services delivered by non-physician professionals, likely represents heightened utilization of mental health services, a trend that predated but was amplified by the coronavirus pandemic. For more information about mental health spending in the state, see the sidebar.

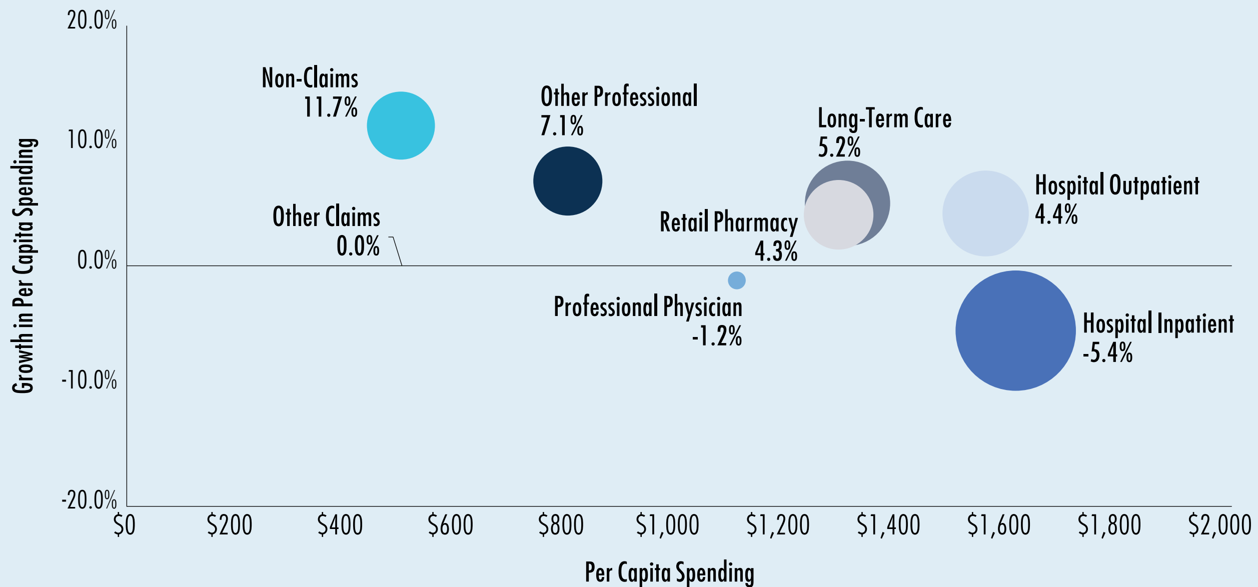
Drivers of Statewide Spending Growth

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.[6] At the state level, Hospital Outpatient and Long-Term Care spending drove overall change in spending in 2022 (see Exhibit 1.5). Statewide level spending was moderated by the substantial decrease in Hospital Inpatient spending per person. Even though per capita spending on Hospital Inpatient services decreased significantly in 2022, it remained the service category with the highest level of spend.

Mental Health

OHIC's analysis of APCD data shows that professional spending on mental health totaled $100.9 million in 2022 for commercial market enrollees. From 2018 through 2022, per capita spending on mental health increased 70 percent for children and adolescents, and 61 percent for adults. These were primarily driven by an explosion in utilization for both age groups. Use of these services increased substantially from 2018 through 2021, before and through the years of the coronavirus pandemic, and remained high in 2022 for both children and young adults.

Exhibit 1.5: State Level Service Category Contribution to Growth, 2021–2022



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.

6 Contribution to overall spending growth was calculated by taking the absolute difference in per capita spending between 2021 and 2022 for each service category and dividing it by the sum of the absolute differences in per capita spending between 2021 and 2022 for all service categories.

CHAPTER 2

Health Care Spending Growth by Insurer & Market and Market-Specific Cost Drivers

To create shared accountability for health care spending across the state, OHIC publicly reports on insurers' performance against the cost growth target. This chapter presents 2022 performance against the cost growth target for each insurer by market, and cost drivers for each market.

Insurers' Spending Growth by Market

OHIC reports performance against the target for insurers in the commercial, Medicare Advantage, and Medicaid Managed Care markets who had at least 5,000 enrolled members in the respective market. OHIC assesses insurers' performance by analyzing annual growth in per person spending on health care and conducts statistical testing using a 95 percent confidence interval.

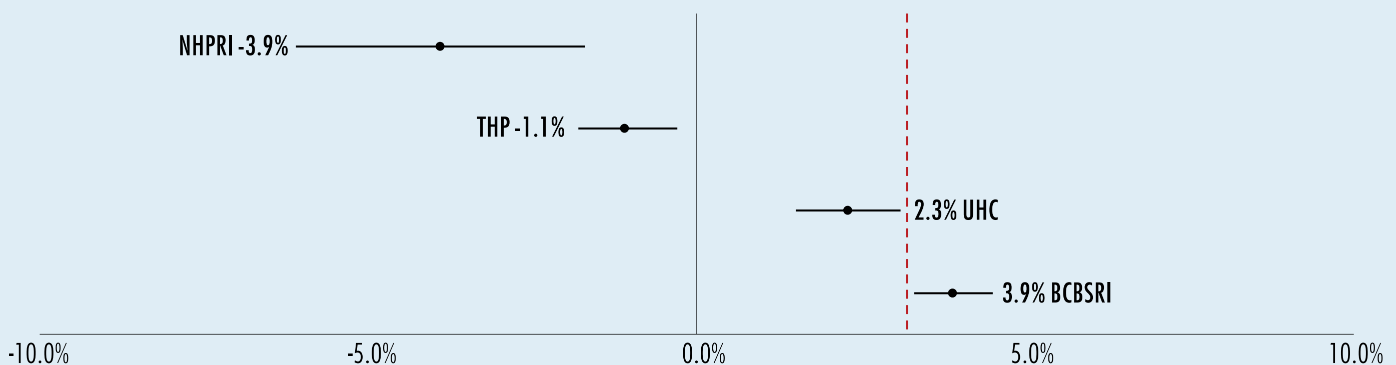
OHIC considers an insurer whose spending growth and confidence interval fall below the target to have met the target. Alternatively, if an insurer's spending growth and confidence interval are above the target, OHIC considers the insurer to have exceeded the target. If the confidence interval intersects with the target, OHIC cannot determine, with statistical certainty, performance against the cost growth target.

Commercial Insurers' Performance Against the Cost Growth Target

OHIC collected data from the state's four largest commercial insurers: Blue Cross Blue Shield of Rhode Island (BCBSRI), Neighborhood Health Plan of Rhode Island (NHPRI), Tufts Health Plan (THP), and UnitedHealthcare (UHC).[1]

Commercial insurers' spending growth in 2022 ranged from –3.9 and 3.9 percent. BCBSRI's per capita spending grew by 3.9 percent, exceeding the target. The three other insurers met the target; THP and NHPRI's per capita spending decreased in 2022, while UHC's increased by 2.3 percent (see Exhibit 2.1).

Exhibit 2.1: Commercial Insurers' 2022 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.[2] Data represent spending on fully insured and self-insured products, including the Federal Employee Health Benefits Program.

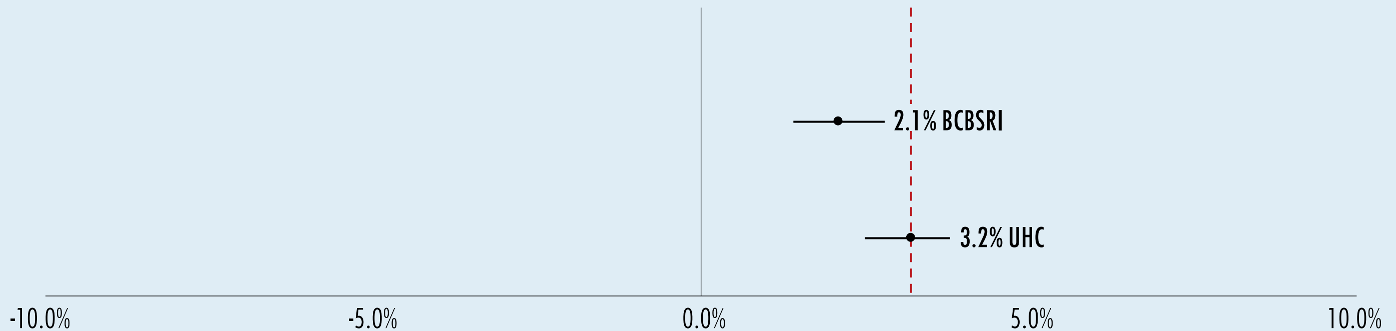
1 Three other insurers, Harvard Pilgrim Health Care, Aetna and Cigna, each had limited market share in Rhode Island's commercial insurance market.

2 OHIC employs truncation, which is the removal of spending above certain dollar thresholds from insurer and provider organization spending calculations, to minimize the impact of high-cost outliers on annual insurer and provider cost growth. OHIC developed member-level truncation points that are specific to each insurance market (commercial, Medicare, and Medicaid). OHIC adjusts insurers' data by age and sex factors (using data submitted by age and sex band) to account for changes in an insurer or provider organization's member/patient population from year to year.
For more information on these methodologies, see: OHIC, *Rhode Island Quality Reporting Implementation Manual*, August 1, 2023, **https://ohic.ri.gov/sites/g/files/xkgbur736/files/2023-08/RI%20Quality%20Implementation%20Manual_CY2022%20v2.0.pdf**.

Medicare Advantage Insurers' Performance Against the Cost Growth Target

BCBSRI and UHC are the Medicare Advantage insurers in Rhode Island. BCBSRI met the cost growth target for the Medicare Advantage market in 2022. Performance for UHC could not be assessed based on statistical testing because its confidence interval intersected with the cost growth target. BCBSRI's Medicare Advantage spending growth was lower than its commercial market growth (see Exhibit 2.2).

Exhibit 2.2: Medicare Advantage Insurers' 2022 Performance Against the Cost Growth Target



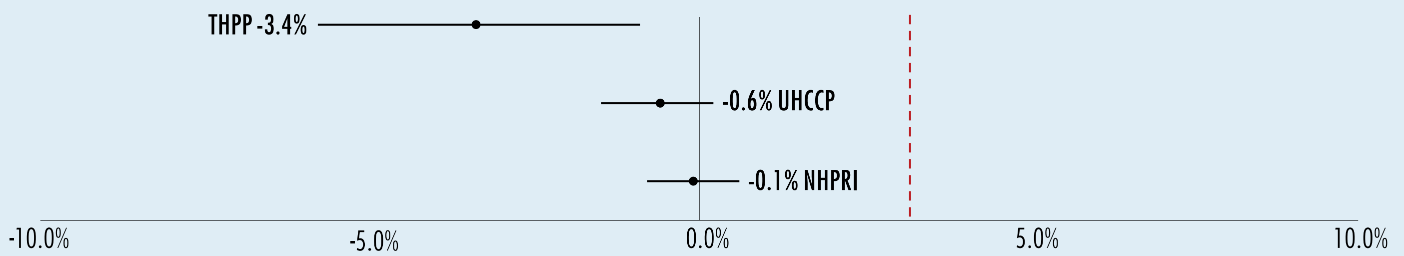
Source: OHIC analysis of TME data from insurers. Target performance is calculated using TME data, after applying truncation and age/sex risk adjustment.

Medicaid Insurers' Performance Against the Cost Growth Target

The three Medicaid insurers in Rhode Island are NHPRI, Tufts Health Public Plans (THPP), and UnitedHealthcare Community Plan (UHCCP).

All Medicaid insurers met the cost growth target, as each experienced a decrease in per capita spending in 2022 (see Exhibit 2.3). This is likely due to the public health emergency's requirement for Medicaid to maintain eligibility. Some of those members who remained eligible may have obtained commercial coverage and stopped using their Medicaid coverage. This continued to have a dramatic effect for THPP because of its low membership, magnifying the impact of a large influx of members in 2022. THPP saw a 17 percent increase in membership, while UHCCP and NHPRI's membership grew at approximately 6 and 3 percent, respectively.

Exhibit 2.3: Medicaid Insurers' 2022 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 has provided coverage to individuals who are dually eligible for Medicare and Medicaid through a combined Medicare-Medicaid Plan (MMP).[3] NHPRI was the only insurer to offer such a product in 2022. 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 2022 performance period, NHPRI's MMP spending growth was 11.8 percent, which exceeded the target. This was primarily driven by an increase in members' home care costs and increased Hospital Outpatient spending.

3 For more information on Integrity, see: Neighborhood Health Plan of Rhode Island, *Neighborhood INTEGRITY (Medicare-Medicaid Plan)*, accessed March 7, 2024, https://www.nhpri.org/medicare-medicaid.

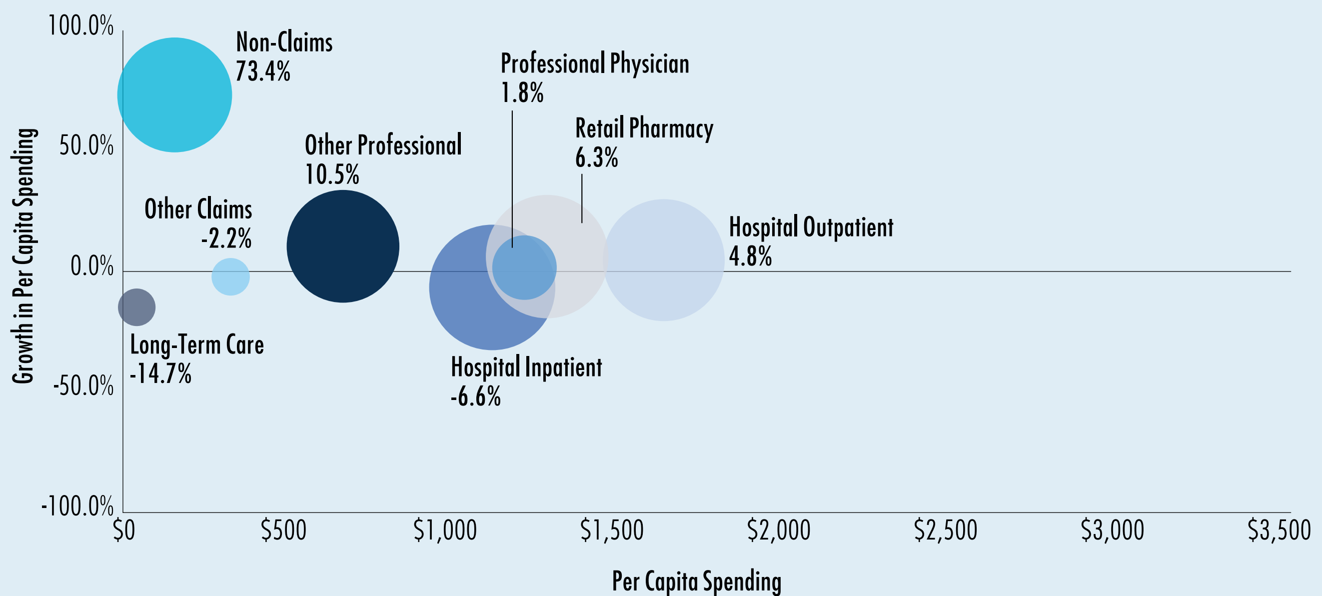
Market-Specific Cost Drivers

Commercial Service Category Cost Drivers

Per capita spending in the commercial market was driven by growth in Retail Pharmacy and Hospital Outpatient spending. Other Professional and Professional Physician Services also contributed to growth, although to a lesser extent.

Per capita spending on Retail Pharmacy increased by 6.3 percent, from $1,196 to $1,271. Hospital Outpatient spending increased 4.8 percent, from $1,547 to $1,621. Notably, Non-Claims payments increased 73.4 percent, from $89 to $154. On the other hand, spending on Hospital Inpatient services decreased by 6.6 percent, from $1,185 to $1.107 (see Exhibit 2.4).

Exhibit 2.4: Commercial Service Category Contribution to Growth, 2021–2022



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.

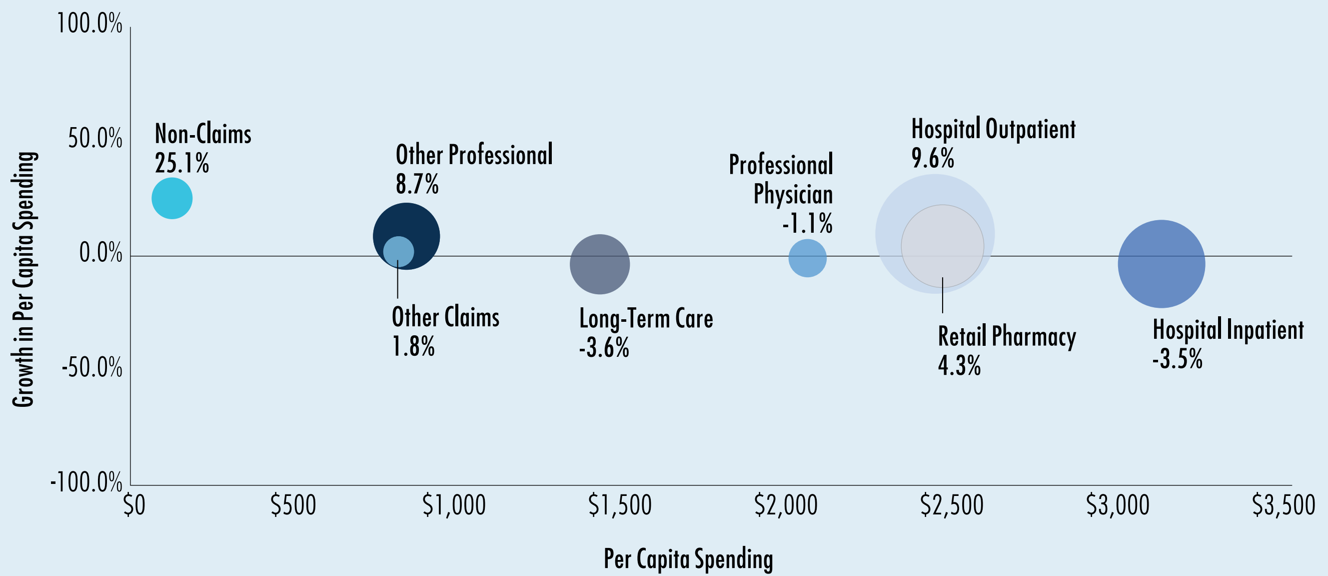
Medicare Service Category Cost Drivers

The growth in Hospital Outpatient services spending was the primary driver of spending growth for the Medicare Market in 2022 (see Exhibit 2.5). On a per person basis, spending on Hospital Outpatient Services increased nearly 10 percent, from $2,212 to $2,425.

Other Professional and Retail Pharmacy spending also contributed to spending growth for this market. Other Professional services increased from $766 to $833 per person, equivalent to an increase of 8.7 percent. Retail Pharmacy spending increased 4.3 percent, from $2,346 to $2,447.

Non-Claims payments, while relatively small, increased 25 percent, largely owing to increased capitation arrangements between Medicare Advantage insurers and providers in the state.

Exhibit 2.5: Medicare Service Category Contribution to Growth, 2021–2022



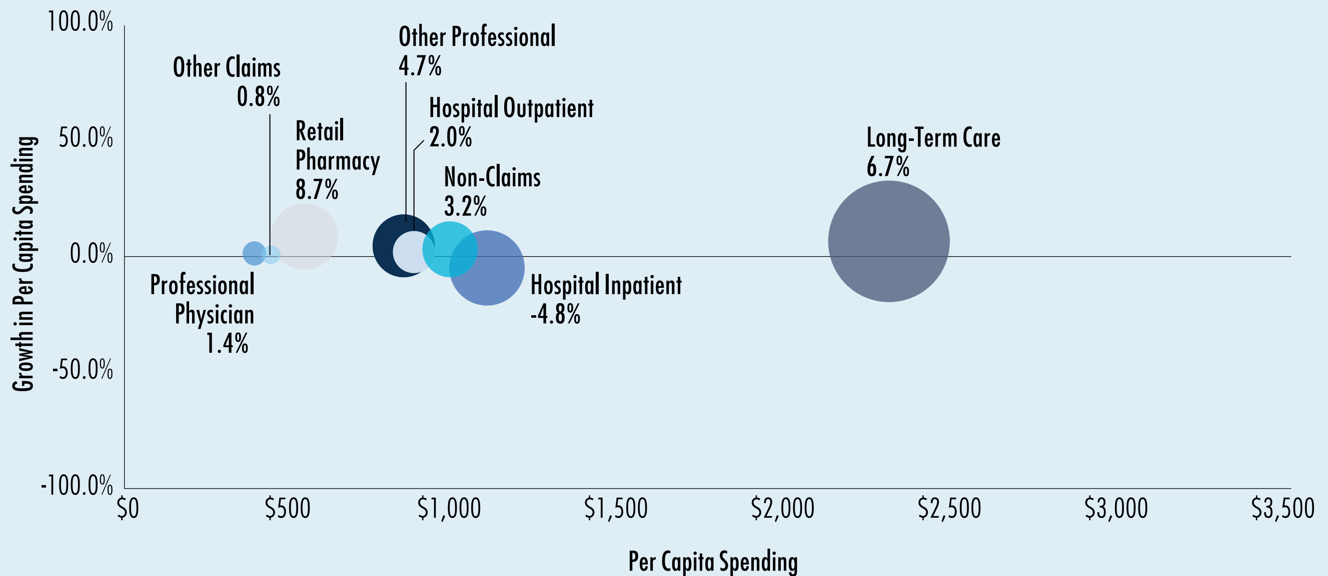
Source: OHIC analysis of TME data from insurers. Data are not risk-adjusted and are reported net of pharmacy rebates. The width of the bubbles represents contribution to spending growth.

Medicaid Service Category Cost Drivers

Long-Term Care spending was the primary driver of Medicaid spending growth in 2022. Retail Pharmacy, Other Professional Services, and Hospital Outpatient spending also contributed to growth, but to a much lesser extent. This contrasts with the commercial and Medicare markets, where these three service categories were largely responsible for spending growth.

Long-Term Care spending increased by 6.7 percent, growing from $2,151 to $2,294. Retail Pharmacy spending grew by 8.7 percent, from $497 to $540 and Other Professional services spending increased 4.7 percent, from $800 to $838. Per person spending on Hospital Outpatient services increased 2 percent, from $853 to $870 (see Exhibit 2.6). Non-Claims payments increased 3.2 percent, which is reflective of the increased supplemental payments from EOHHS to providers.

Exhibit 2.6. Medicaid Service Category Contribution to Growth, 2021–2022



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.

CHAPTER 3

Health Care Spending Growth by Provider & Market

Providers' Spending Growth by Market

Accountable Care Organizations, or ACOs, are provider organizations contracted with one or more insurers and are held accountable for the health care quality, outcomes, and total cost of care of an attributed commercial or Medicare population. In Rhode Island's Medicaid market, these provider organizations are called Accountable Entities (AEs) and are certified by EOHHS. OHIC assesses performance against the target for ACOs and AEs that have at least 5,000 attributed members.[1] This chapter presents 2022 performance against the cost growth target for each provider by market.

ACO Commercial Performance Against the Cost Growth Target

There were eight ACOs contracted with commercial insurers in Rhode Island in 2022. Commercial spending 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. Among the four ACOs that had sufficient attributed lives for performance to be publicly reported, three exceeded the cost growth target for the 2022 performance period (see Exhibit 3.1). Coastal's performance could not be assessed based on statistical testing because its confidence interval intersected with the cost growth target. The range of spending growth of ACOs in the commercial market is much higher than that of commercial insurers (4 to 7 percent for ACOs, -4 to 4 percent for insurers). This is an expected finding because non-users of health care services are enrolled with insurers, but are not attributed to ACOs given Rhode Island's predominantly Preferred Provider Organization (PPO) commercial market.

Exhibit 3.1: ACOs' 2022 Commercial Market Performance Against the Cost Growth Target

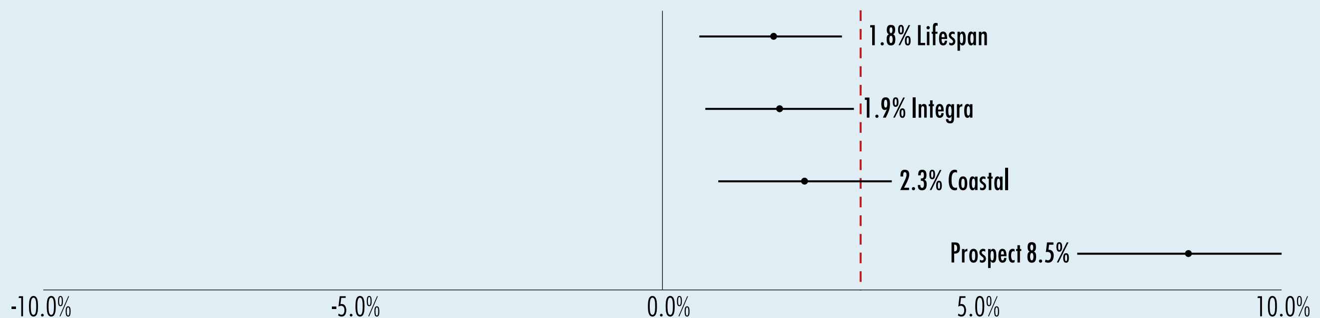
Source: OHIC analysis of TME data from insurers. Target performance is calculated using truncated and age/sex risk-adjusted spending.

1 Attribution refers to the practice of insurers assigning patients to provider organizations, primarily through evidence of patient relationships with primary care clinicians affiliated with the organization. Attribution is performed to inform insurer/provider organization contractual terms and for other purposes.

ACO Medicare Advantage Performance Against the Cost Growth Target

There were eight Medicare ACOs in Rhode Island in 2022. 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 – Lifespan and Integra met the cost growth target for the 2022 performance period (see Exhibit 3.2). As was the case for the commercial market, Coastal's Medicare Advantage performance could not be assessed based on statistical testing because its confidence interval intersected with the cost growth target. Prospect CharterCARE's (Prospect) Medicare Advantage growth exceeded the cost growth target and was higher than its commercial spending growth.

Exhibit 3.2: ACOs' 2022 Medicare Advantage Market Performance Against the Cost Growth Target

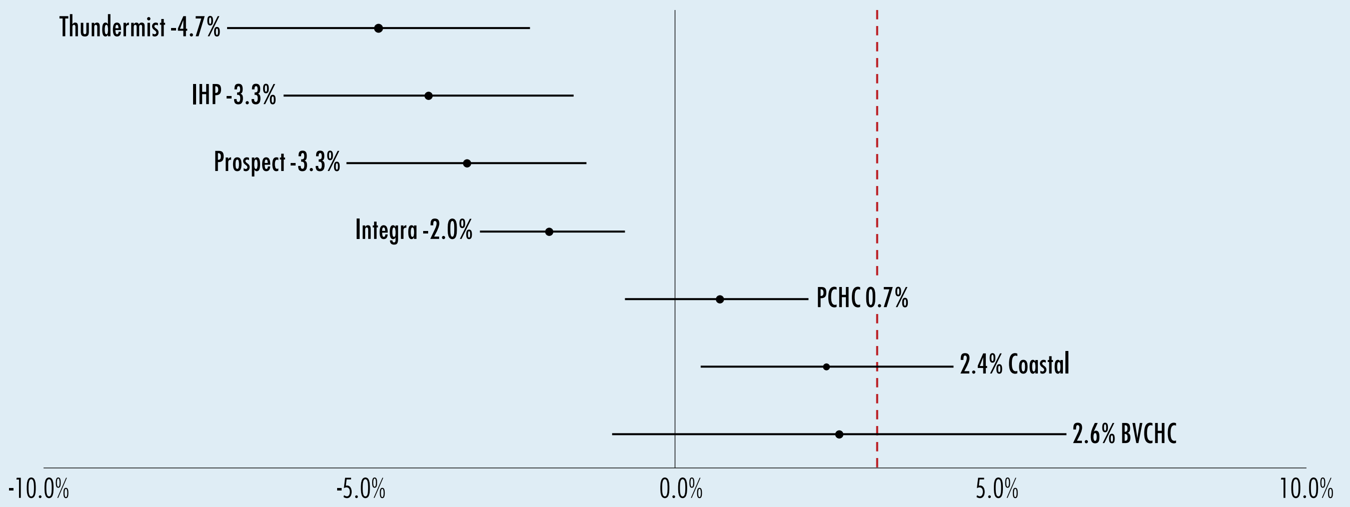


Source: OHIC analysis of TME data from insurers. Target performance is calculated using truncated and age/sex risk-adjusted spending.

AE Medicaid Performance Against the Cost Growth Target

There were seven Medicaid AEs in Rhode Island in 2022. Medicaid spending growth is not presented for Lifespan because it did not hold a total cost of care contract with any Medicaid insurer in 2022. Performance for two AEs (BVCHC and Coastal) could not be assessed based on statistical significance testing because their confidence interval intersected with the cost growth target (see Exhibit 3.3). The remaining five AEs met the cost growth target, and the range of spending growth of Medicaid AEs is similar to that of Medicaid insurers (–5 to 1 percent for ACOs, –3 to 0 percent for insurers). The similarity reflects the HMO product that EOHHS purchases from insurers.

Exhibit 3.3: AEs' 2022 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.

CHAPTER 4

Deep Dive on Hospital Outpatient Spending

Spending on Hospital Outpatient services has been the key driver of statewide spending in Rhode Island for multiple years.[1] In 2022, per capita spending on Hospital Outpatient services across all markets in Rhode Island totaled $1,554, making up 18 percent of overall spending on medical services (see Exhibit 1.4). When looking at just the commercial market in Rhode Island, Hospital Outpatient services account for about a quarter of total medical spending. Given the outsized role that this service category plays in rising health care costs in Rhode Island, OHIC conducted deep dive analyses to better understand trends in Hospital Outpatient spending in the commercial market using Rhode Island's All-Payer Claims Database (APCD), HealthFacts RI.[2] This chapter presents the results of these analyses.

Trends in Hospital Outpatient Spending

From 2018 to 2022, per member per month (PMPM) spending on Hospital Outpatient services for those with commercial insurance coverage in Rhode Island increased 17.9 percent, or at an average of 4.5 percent annually. A breakdown of changes in payment per unit (PPU) and utilization in units per 1,000 members (UPK) over this five-year period shows that increases in both metrics contributed to the overall increase in PMPM spending on Hospital Outpatient services (see Table 4.1).

Table 4.1: PMPM, PPU, and UPK for Hospital Outpatient Services for Rhode Island Residents with Commercial Insurance Coverage

Year	PMPM	PPU	UPK
2018	$117	$752	1,872
2019	$125	$776	1,928
2020	$113 17.9%	$770 8.8%	1,761 8.0%
2021	$130	$759	2,053
2022	$138	$818	2,021
Average Annual Growth	**4.5%**	**2.2%**	**2.3%**

Source: OHIC analysis of HealthFacts RI data.

Drivers of Spending on Hospital Outpatient Services

Two of the higher cost Hospital Outpatient service categories are ambulatory surgery and drugs, the latter inclusive of chemotherapy and other infusion drugs that are sometimes administered in the outpatient setting. In 2022, Outpatient Surgery comprised only two percent of the overall volume of Hospital Outpatient services, but accounted for 31 percent of total Hospital Outpatient spending. Meanwhile, Administered Drugs made up only five percent of the overall volume of Hospital Outpatient services, but accounted for 17 percent of spending.

1 Hospital Outpatient was a primary cost growth driver at the state level in 2021 – per person spending on this category increased 13 percent. OHIC, *Health Care Spending and Quality in Rhode Island: 2021 Performance*. May 8, 2023. https://ohic.ri.gov/sites/g/files/xkgbur736/files/2023-05/public%20forum%202023%2005-08%20cost%20trends%20and%20quality%20reporting%20for%202021_EMBEDDED.pdf. It was also a cost growth driver in 2019, when spending increased over 7 percent: OHIC, *Performance against the 2019 cost growth target*. 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.
Hospital Outpatient was not a cost growth driver in 2020 – spending on this category decreased 10 percent for that performance year. 2020 was a unique reporting year because of aberrant health care utilization and spending during the COVID-19 pandemic.

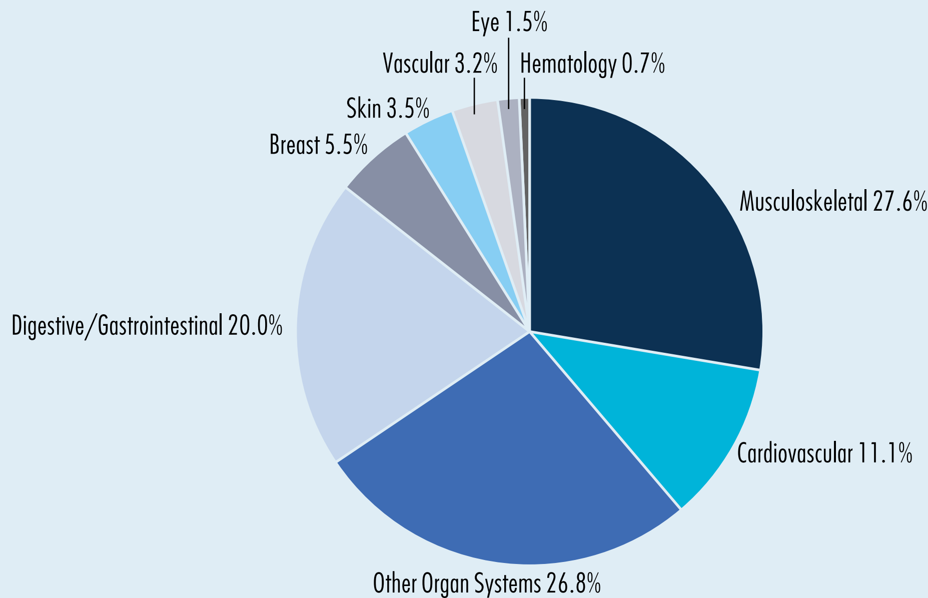
2 The APCD represents approximately 80 percent of commercial spending in the state due to the absence of data from some self-insured employers. As such, figures where "total" spending is indicated are understated.

Deep Dive into Outpatient Surgery

2022 Snapshot of Musculoskeletal Procedures

In 2022, 27.6 percent of spending on outpatient surgeries were for musculoskeletal conditions such as arthritis, torn or damaged cartilage, and joint inflammation. Twenty percent were for digestive and gastrointestinal issues such as Crohn's Disease, ulcers, gastritis, and 11.1 percent were for cardiovascular conditions (see Exhibit 4.1).

Exhibit 4.1: Outpatient Surgery Share of Spending by Type of Service, 2022

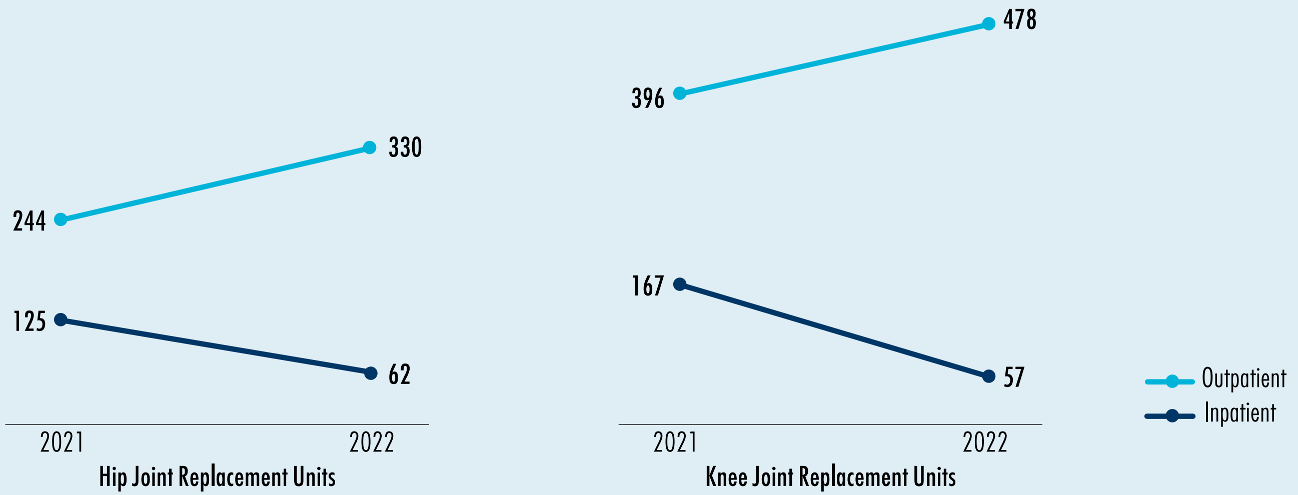


Source: OHIC analysis of HealthFactsRI data.

The average PPU in 2022 for Outpatient Surgery was $3,514 and the average PPU for musculoskeletal procedures was $4,555, which was higher than any other surgery subcategory with similar utilization.

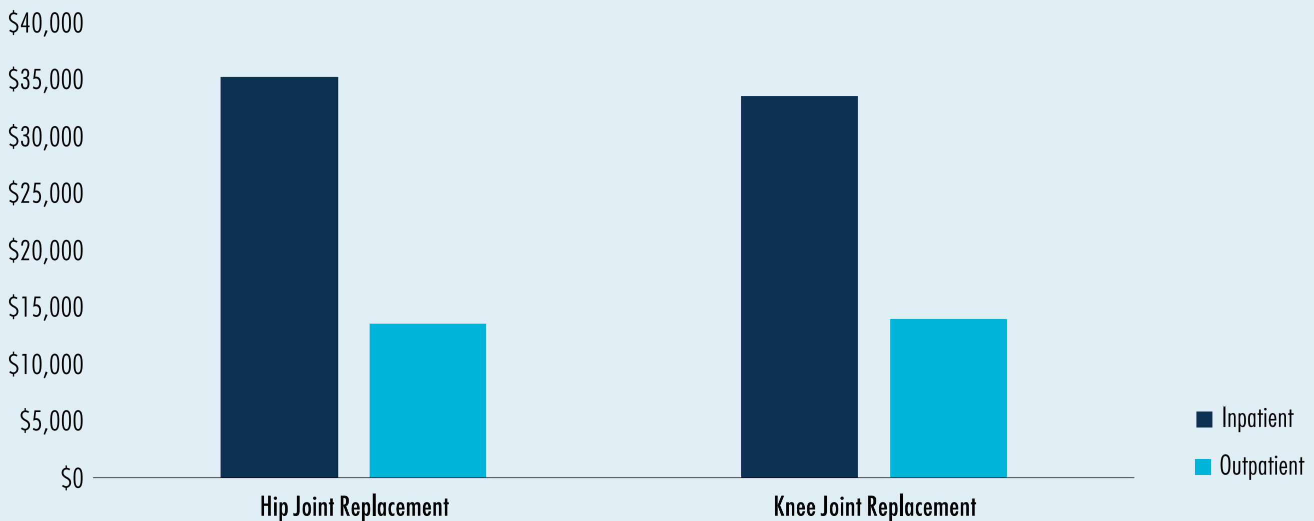
Further analysis of musculoskeletal procedures presents an interesting picture. A key contributing factor behind the 7.8 percent jump in Hospital Outpatient PPU in 2022 (i.e., $759 to $818) may have been the movement of hip and knee joint replacement surgeries from the inpatient hospital setting to the outpatient hospital setting. In Rhode Island, the number of hip replacements performed on an outpatient basis increased 35 percent from 244 in 2021 to 330 in 2022. This corresponded with a 50 percent decrease in hip replacements performed on an inpatient basis from 125 in 2021 to 62 in 2022. Utilization of knee replacements followed a similar pattern (see Exhibit 4.2). While these surgeries are among the outpatient services with the highest per unit payment, they cost significantly less when performed on an outpatient basis instead of an inpatient basis. In 2022, the average PPU for an inpatient hip replacement was more than double the average PPU for an outpatient hip replacement ($35,000 vs. $13,500); the difference was similar for a knee replacement ($33,500 vs. $13,900) (see Exhibit 4.3).

Exhibit 4.2: Shift in Joint Replacements from Hospital Inpatient to Hospital Outpatient, 2021–2022



Source: OHIC analysis of HealthFacts RI data.

Exhibit 4.3: Difference in Average PPU for Inpatient and Outpatient Joint Replacements, 2022



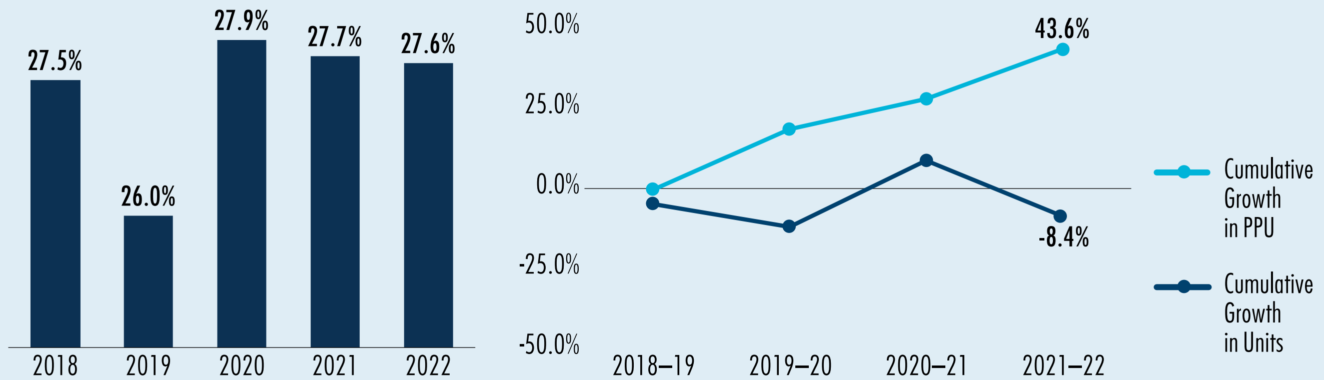
Source: OHIC analysis of HealthFacts RI data.

The movement of joint replacement surgery from the inpatient to outpatient setting appears to be a factor in driving the high payments for outpatient surgery in 2022. Data show that knee and joint replacements' role in contributing to high spending for musculoskeletal procedures is not isolated to 2022.

Trends in Spending on Musculoskeletal Procedures

Over time, overall spending on musculoskeletal surgeries compared to other outpatient surgeries has been relatively stable (see Exhibit 4.4(a)). However, between 2018 and 2022, the average number of outpatient musculoskeletal surgeries performed decreased, and the average unit payment increased dramatically, at an average 10 percent per year (see Exhibit 4.4(b)).

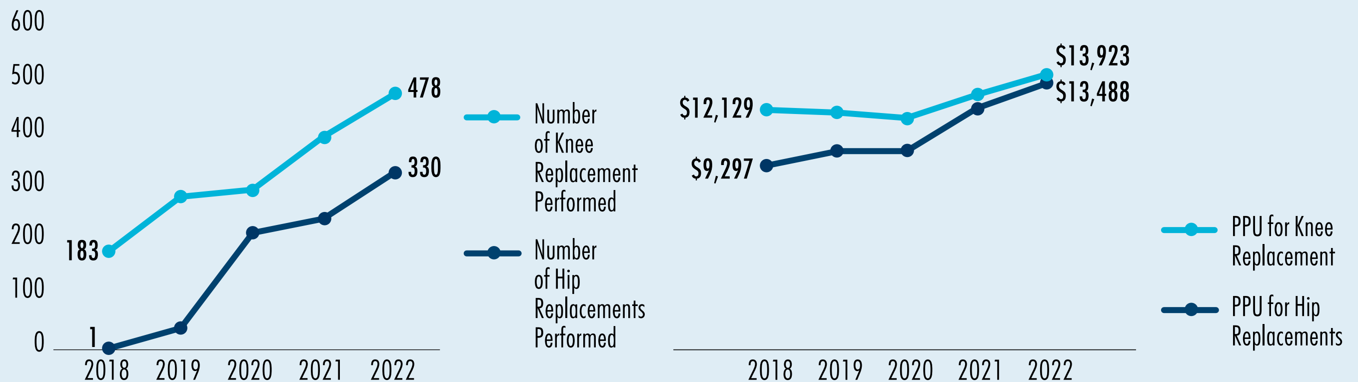
Exhibit 4.4: (a) Musculoskeletal % of Outpatient Surgery Spending, 2018–2022 and (b) Cumulative Growth in PPU and Cumulative Growth in Units of Outpatient Musculoskeletal Procedures, 2018–2022



Source: OHIC analysis of HealthFactsRI data.

Notably, when focusing on hip and knee replacements, both utilization and average payments rose over this period (see Exhibits 4.5(a) and 4.5(b)). These costly services contributed to growing unit payments for musculoskeletal procedures between 2018 and 2022.

Exhibit 4.5: (a) Units of Hip and Knee Replacements, 2018–2022 and (b) PPU for Hip and Knee Replacements, 2018–2022



Source: OHIC analysis of HealthFactsRI data.

Deep Dive into Administered Drugs

2022 Snapshot for Administered Drugs

In 2022, the average PPU for Administered Drugs overall increased 12 percent, from $879 to $989 while utilization remained flat. The category of drugs with the most spending was chemotherapeutic agents, which are used to treat cancer and are often high-priced therapies. These drugs accounted for more than 50 percent of total administered drug spending, but only 20 percent of the total volume of administered drugs in 2022.

Further analysis reveals that in 2022, the two chemotherapy drugs with the highest spending were Keytruda (pembrolizumab) and Darzalex Faspro (daratumumab, hyaluronidase), which represented $5.0 million and $2.9 million of spending, respectively. Keytruda, which is used to treat melanomas and other types of cancers, was the drug with the most spending in both 2021 to 2022. At the same time, spending for Darzalex, which treats different kinds of blood cancers, more than tripled from $0.8M to $2.9M; as a result, it transitioned from being a drug with comparatively low total spending, to being the chemotherapy drug with the second highest spending (see Table 4.2). This growth in spending was driven by dramatic growth in utilization of this treatment in 2022. The increased utilization of Keytruda and Darzalex, both of which are very expensive, likely played a role in the increased average payment for administered drugs overall in 2022.

As was the case with Outpatient Surgeries, OHIC examined historical data on Administered Drugs to better understand longer-term trends..

Table 4.2: Spending, UPK, and PPU for Keytruda and Darzalex, 2021–2022

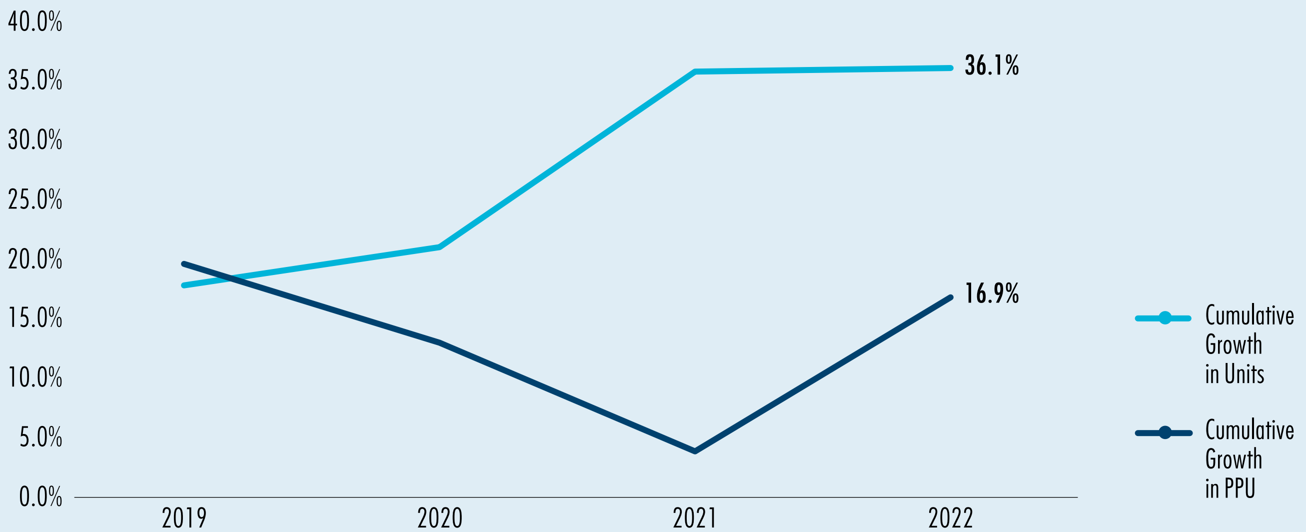
Top 4 Spend Drugs in 2022 (Brand Name)	2021 Spend (in millions)	2021 Units	2021 PPU	2022 Spend (in millions)	2022 Units	2022 PPU	Rank by Total Spending in 2021	Rank by Total Spending in 2022
J9271 (Keytruda)	$3.5	340	$10,318	$5.0	438	$11,401	1	1
J9144 (Darzalex)	$0.8	89	$8,428	$2.9	286	$9,972	14	2

Source: OHIC analysis of HealthFactsRI data.

Trends in Spending on Administered Drugs

From 2018 through 2022, utilization and average payments for Administered Drugs both increased substantially. Utilization grew at an average of nine percent annually while PPU increased at an average of 4.2 percent per year (see Exhibit 4.6).

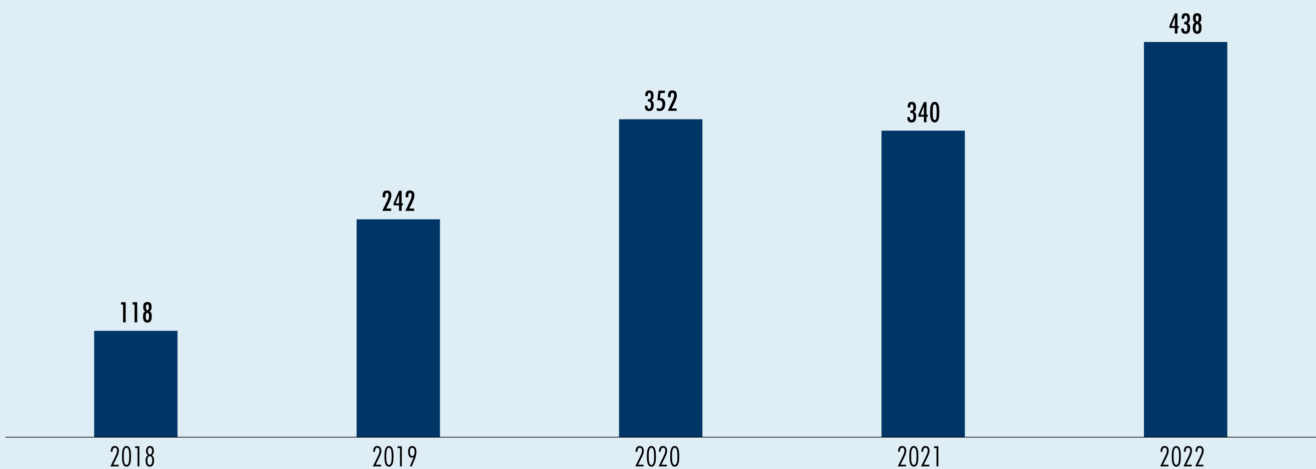
Exhibit 4.6: Cumulative Growth in Units and Cumulative Growth in PPU for Administered Drugs, 2018–2022



Source: OHIC analysis of HealthFactsRI data.
Note: The y-axis represents the year for which growth is shown (e.g., 2019 represents change from 2018 to 2019).

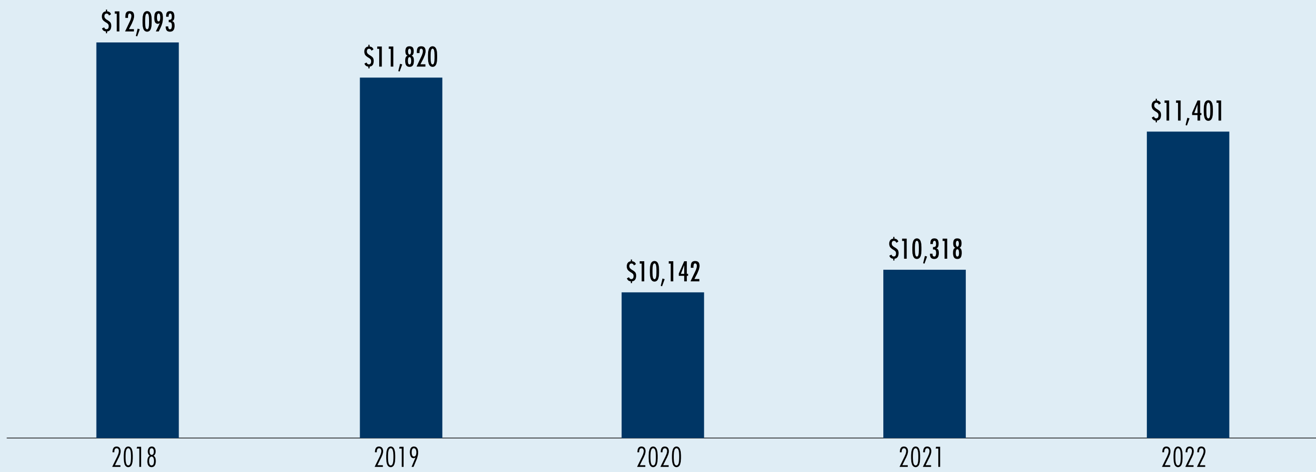
Low unit counts led to fluctuations in average payments over time. For example, utilization of Keytruda increased nearly three-fold from 2018 through 2022, but PPU bounced up and down (see Exhibits 4.7(a) and 4.7(b)). Other Administered Drugs follow this pattern of increased utilization but fluctuating unit payments. Over these five years, the significant growth in utilization of expensive drugs drove spending on Administered Drugs in Rhode Island for the commercial market more so than observed growth in PPU.

Exhibit 4.7(a): Units for Keytruda, 2018–2022



Source: OHIC analysis of HealthFactsRI data.

Exhibit 4.7(b): PPU[1] for Keytruda, 2018–2022



Source: OHIC analysis of HealthFactsRI data.

1 There were fluctuations in PPU for Keytruda because this drug is used to treat several conditions, and price varies by indication.

Reflections on Hospital Outpatient Spending

Hospital Outpatient services play a key role in Rhode Island's health care spending growth. Two categories of services, Outpatient Surgery and Administered Drugs, have each contributed to this increased spending. In 2022, the increase of expensive joint replacements being performed in an outpatient, rather than inpatient, setting contributed to growth in higher average payment for outpatient procedures. As for Administered Drugs, very expensive drugs were used more frequently, which contributed to the rising payments for this category. Each of these 2022 phenomena are reflective of multi-year trends. These deeper analyses provide insights to Rhode Islanders on drivers of spending growth so that future policy decisions are informed by data.

CHAPTER 5

Health Care Quality, Public Health and Health Equity

OHIC reports health care quality, public health and health equity data to complement annual public reporting of spending growth and offer a balanced perspective on health system performance. This examination serves two purposes: 1) it safeguards against potential stinting of care and protecting patients' interests in the context of a spending growth target; and 2) it establishes improved public health and health equity as a twin state objective of improved affordability. OHIC reports performance on two quality measure sets:

- **ACO Aligned Measure Set:** 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 Entity (AE) program requires measurement and reporting of AE quality performance using the Medicaid AE Common Measure Slate, which EOHHS voluntarily aligns with the OHIC 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 spending growth target, the Cost Trends Steering Committee recommended using OHIC's existing ACO Core Measure Set to monitor quality alongside spending growth.[3]
- **Public Health and Health Equity Measures:** In 2023, 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. OHIC convened a Public Health and Health Equity Target Measures Work Group in 2023, which recommended six measures for inclusion. The measures are related to behavioral health, childhood obesity, health care access and maternal and infant health. State-level performance is assessed using data available from the Rhode Island Department of Health (RIDOH) or from other public sources. OHIC will begin to report annually against performance targets for 2027.

This chapter presents 2022 commercial and Medicaid quality performance data for the Core Measures in OHIC's ACO Aligned Measure Set, and Rhode Island's baseline performance on the six Public Health and Health Equity Measures.

What Are OHIC's Aligned Measure Sets?

Since 2015, OHIC has maintained a common set of quality measures 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. Each of the measure sets includes 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.

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*, January 31, 2024, **https://ohic.ri.gov/sites/g/files/xkgbur736/files/2024-02/Aligned%20Measure%20Set%20Interpretive%20Guidance%202024%201-31%20final.pdf**.

3 For details on the data collection and analysis methodology, see: OHIC, *Rhode Island Quality Reporting Implementation Manual*, August 1, 2023, **https://ohic.ri.gov/sites/g/files/xkgbur736/files/2023-08/RI%20Quality%20Implementation%20Manual_CY2022%20v2.0.pdf**.

Aligned Measure Set Performance

2022 ACO Core Measure Set

The 2022 ACO Core Measure Set contained the following eight measures addressing three domains: chronic illness, behavioral health, and preventive care:

- Breast Cancer Screening
- Colorectal Cancer Screening
- Controlling High Blood Pressure
- Eye Exam for Patients with Diabetes
- Follow-Up After Hospitalization for Mental Illness (7-Day)
- Hemoglobin A1c (HbA1c) Control for Patients with Diabetes: HbA1c Control (<8.0%)
- Child and Adolescent Well-Care Visits (ages 12–21)
- Developmental Screening in the First Three Years of Life

OHIC obtains commercial performance on the ACO Core Measure Set measures directly from insurers as part of the spending growth target data collection.[4] The Rhode Island Executive Office of Health and Human Services (EOHHS) provides the data to calculate Medicaid performance on the ACO Core Measure Set measures.[5]

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 for which national benchmarks were available, and exceeded the national 90th percentile on all but one of the measures, *HbA1c Control* (see Table 5.1).[6]

Table 5.1: 2022 Statewide Commercial Performance on the ACO Core Measure Set

Measure	National Benchmarks		Statewide Performance	
	75TH PCTL	90TH PCTL	ABOVE 75TH PCTL?	ABOVE 90TH PCTL?
Breast Cancer Screening	76%	78%	Yes 86%	Yes 86%
Colorectal Cancer Screening	59%	66%	Yes 78%	Yes 78%
Controlling High Blood Pressure	66%	72%	Yes 74%	Yes 74%
Eye Exam for Patients with Diabetes	55%	61%	Yes 71%	Yes 71%
Follow-Up After Hospitalization for Mental Illness (7-Day)	53%	58%	Yes 58%	Yes 58%
HbA1c Control (<8.0%)	63%	67%	Yes 63%	No 63%
Child and Adolescent Well-Care Visits (ages 12–21)	NA	NA	76%	76%
Developmental Screening in the First Three Years of Life	78%	81%	Yes 86%	Yes 86%

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 measurement data using population samples.

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*, August 1, 2023, https://ohic.ri.gov/sites/g/files/xkgbur736/files/2023-08/RI%20Quality%20Implementation%20Manual_CY2022%20v2.0.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 29, 2023, https://eohhs.ri.gov/media/43416/download?language=en.

6 National benchmarks were not available for *Child and Adolescent Well-Care Visits (ages 12–21)* because NCQA only publishes benchmarks for the separate 12–17 and 18–21 age bands.

Statewide Medicaid Performance on the ACO Core Measure Set

For 2022, the AE Common Measure Slate did not include *Colorectal Cancer Screening*. Therefore, Medicaid performance could only be reported on seven of the eight ACO Core Measures. Rhode Island exceeded the national 75th percentile for the Medicaid market on all measures except one for which benchmarks were available and exceeded the national 90th percentile on three of the measures. Medicaid performance was better for the preventive care measures than the chronic illness and behavioral health measures (with the exception of *Eye Exam for Patients with Diabetes*) (see Table 5.2). 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 5.2: 2022 Statewide Medicaid Performance on the ACO Core Measure Set

Measure	National Benchmarks		Statewide Performance	
	75TH PCTL	90TH PCTL	ABOVE 75TH PCTL?	ABOVE 90TH PCTL?
Breast Cancer Screening	58%	63%	Yes 63%	Yes 63%
Colorectal Cancer Screening	NA	NA	--	--
Controlling High Blood Pressure	67%	72%	Yes 68%	No 68%
Eye Exam for Patients with Diabetes	59%	63%	Yes 64%	Yes 64%
Follow-Up After Hospitalization for Mental Illness (7-Day)	44%	53%	Yes 51%	No 51%
HbA1c Control (<8.0%)	57%	60%	No 56%	No 56%
Child and Adolescent Well-Care Visits (ages 12–21)	NA	NA	55%	55%
Developmental Screening in the First Three Years of Life	78%	81%	Yes 84%	Yes 84%

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 data for their full population.

Insurers’ Performance on the ACO Core Measure Set

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 chronic illness and diabetes care measures.[7] The three insurers were above the National 75th percentile for all measures, except THP for *Controlling High Blood Pressure* and *HbA1c Control*. The insurers were above the 90th percentile for all measures except UHC for *Follow-Up After Hospitalization for Mental Illness (7-Day)* and all three insurers for *HbA1c Control*. BCBSRI’s performance compared favorably, and in some cases substantially so, to the other insurers on all but one measure (*HbA1c Control*) (see Table 5.3).

Table 5.3: 2022 Commercial Insurers’ Performance on the ACO Core Measure Set

Measure	National Benchmarks		Above 75th Percentile?			Above 90th Percentile?		
	75TH PCTL	90TH PCTL	BCBSRI	THP	UHC	BCBSRI	THP	UHC
Breast Cancer Screening	76%	78%	Yes 88%	Yes 86%	Yes 80%	Yes 88%	Yes 86%	Yes 80%
Colorectal Cancer Screening	59%	66%	Yes 83%	Yes 66%	Yes 67%	Yes 83%	Yes 66%	Yes 67%
Controlling High Blood Pressure	66%	72%	Yes 76%	No 52%	Yes 72%	Yes 76%	No 52%	Yes 72%
Eye Exam for Patients with Diabetes	55%	61%	Yes 74%	Yes 61%	Yes 62%	Yes 74%	Yes 61%	Yes 62%
Follow-Up After Hospitalization for Mental Illness (7-Day)[8]	53%	58%	NA	Yes 71%	Yes 56%	NA	Yes 71%	No 56%
HbA1c Control (<8.0%)	63%	67%	Yes 64%	No 45%	Yes 65%	No 64%	No 45%	No 65%
Child and Adolescent Well-Care Visits (ages 12–21)	NA	NA	79%	73%	67%	79%	73%	67%
Developmental Screening in the First Three Years of Life[9]	78%	81%	Yes 86%	Yes 80%	NA	Yes 86%	No 80%	NA

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

Note: NA = Not Available. Insurer did not submit performance on this measure. NHPRI is not included in the analysis because it does not hold total cost of care contracts with ACOs for its commercial members.

7 NHPRI is not included in the analysis because it does not hold total cost of care contracts with ACOs for its commercial members.
8 BCBSRI failed to comply with OHIC’s mandated utilization of Core Measures by omitting *Follow-Up After Hospitalization for Mental Illness* from its 2022 quality incentive program, resulting in the absence of reported data for 2022.
9 UHC failed to comply with OHIC’s mandated utilization of Core Measures by omitting *Developmental Screening in the First Three Years of Life* from its 2022 commercial contracts, resulting in the absence of reported data for 2022.

Medicaid Insurers' Performance on the ACO Core Measure Set

Medicaid insurer performance on the ACO Core Measure Set was better for the preventative care measures and behavioral health measure than for the chronic illness measures. The two Medicaid insurers (NHPRI and UHCCP) were both above the National 75th percentile for all measures with the exception of UHCCP for *HbA1c Control*. There was only one measure for which both insurers were above the 90th percentile – *Developmental Screening in the First Three Years of Life*. For 2022, the AE Common Measure Slate did not include *Colorectal Cancer Screening*, therefore Medicaid performance could not be reported for this measure (see Table 5.4).

Table 5.4: 2022 Medicaid Insurers' Performance on ACO Core Measure Set

Measure	National Benchmarks		Above 75th Percentile?		Above 90th Percentile?	
	75TH PCTL	90TH PCTL	NHPRI	UHCCP	NHPRI	UHCCP
Breast Cancer Screening	58%	63%	Yes 65%	Yes 60%	Yes 65%	No 60%
Colorectal Cancer Screening	NA	NA	NA	NA	NA	NA
Controlling High Blood Pressure	67%	72%	Yes 67%	Yes 69%	No 67%	No 69%
Eye Exam for Patients with Diabetes	59%	63%	Yes 65%	Yes 62%	Yes 65%	No 62%
Follow-Up After Hospitalization for Mental Illness (7-Day)	44%	53%	Yes 50%	Yes 53%	No 50%	Yes 53%
HbA1c Control (<8.0%)	57%	60%	Yes 57%	No 53%	No 57%	No 53%
Child and Adolescent Well-Care Visits (ages 12–21)	NA	NA	56%	54%	56%	54%
Developmental Screening in the First Three Years of Life	78%	81%	Yes 85%	Yes 81%	Yes 85%	Yes 81%

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

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

Providers' Performance on The ACO Core Measure Set

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

There was significant variation in ACO commercial performance on the ACO Core Measure Set. For example, performance for *Child and Adolescent Well-Care Visits (ages 12–21)* ranged from 44% to 83%. Coastal, Integra, Lifespan, and Prospect performed best for the commercial market, exceeding the 75th for commercial performance for all or almost all the ACO Measure Set measures (Integra did not exceed the 75th percentile for *HbA1c Control* and Prospect did not exceed the 75th percentile for *Developmental Screening in the First Three Years of Life*). BVCHC, PCHC and Thundermist exceeded the 75th percentile for between zero and two measures. This disparity in performance may be due to BVCHC, PCHC and Thundermist's status as FQHCs; they likely serve comparatively lower income populations with more social risk factors than the other ACOs. Finally, it is worth noting that only one ACO/AE (Integra) had a commercial denominator size large enough (> 30) to report performance on *Follow-Up After Hospitalization for Mental Illness (7-Day)* (see Table 5.5).

Table 5.5: 2022 ACO Commercial Performance on the ACO Core Measure Set – 75th Percentile

Measure	Nat'l 75th PCTL	Above 75th Percentile?							
		BVCHC	COASTAL	INTEGRA	IHP	LIFESPAN	PCHC	PROSPECT	THUNDERMIST
Breast Cancer Screening	76%	No 70%	Yes 91%	Yes 83%	NA	Yes 90%	Yes 76%	Yes 85%	No 71%
Colorectal Cancer Screening	59%	No 54%	Yes 85%	Yes 71%	NA	Yes 82%	No 57%	Yes 78%	Yes 64%
Controlling High Blood Pressure	66%	No 48%	Yes 77%	Yes 72%	NA	Yes 71%	No 47%	Yes 78%	No 47%
Eye Exam for Patients with Diabetes	55%	No 51%	Yes 78%	Yes 60%	NA	Yes 73%	No 53%	Yes 72%	Yes 66%
Follow-Up After Hospitaliztn for Mental Illness (7-Day)	53%	NA	NR	Yes 56%	NA	NR	NA	NR	NR
HbA1c Control (<8.0%)	63%	No 53%	Yes 64%	No 56%	NA	Yes 63%	No 31%	Yes 63%	No 44%
Child and Adolescent Well-Care Visits (ages 12–21)	NA	44%	83%	76%	NA	80%	57%	72%	62%
Developmental Screening in the First Three Years of Life	78%	NR	Yes 89%	Yes 80%	NA	Yes 82%	No 75%	No 72%	No 59%

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

Note:
NA = Not Available. Insurers did not submit performance for the ACO/AE.
NR = Not Reported. The ACO/AE did not meet the minimum denominator size required for public reporting.
BCBSRI holds a commercial ACO contract with IHP and was unable to report quality performance for 2022 but has conveyed its intention do so beginning with 2023 performance.

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

None of the ACOs exceeded the national 90th percentile for commercial performance for all of the ACO Core Measure Set measures. Coastal exceeded the 90th percentile for all but one measure – *HbA1c Control*. Integra, Lifespan, PCHC and Prospect exceeded the 90th percentile for three to four measures. Thundermist only exceeded the 90th percentile for one measure (*Eye Exam for Patients with Diabetes*) and BVCHC did not exceed the commercial 90th percentile for any measure (see Table 5.6).

Table 5.6: ACO Commercial Performance on the ACO Core Measure Set – 90th Percentile

Measure	Nat'l 90th PCTL	Above 90th Percentile?							
		BVCHC	COASTAL	INTEGRA	IHP	LIFESPAN	PCHC	PROSPECT	THUNDERMIST
Breast Cancer Screening	78%	No 70%	Yes 91%	Yes 83%	NA	Yes 90%	Yes 76%	Yes 85%	No 71%
Colorectal Cancer Screening	66%	No 54%	Yes 85%	Yes 71%	NA	Yes 82%	No 57%	Yes 78%	No 64%
Controlling High Blood Pressure	72%	No 48%	Yes 77%	Yes 72%	NA	No 71%	No 47%	Yes 78%	No 47%
Eye Exam for Patients with Diabetes	61%	No 51%	Yes 78%	No 60%	NA	Yes 73%	No 53%	Yes 72%	Yes 66%
Follow-Up After Hospitalizatn for Mental Illness (7-Day)	58%	NA	NR	No 56%	NA	NR	NA	NR	NR
HbA1c Control (<8.0%)	67%	No 53%	No 64%	No 56%	NA	No 63%	No 31%	No 63%	No 44%
Child and Adolescent Well-Care Visits (ages 12–21)	--	44%	83%	76%	NA	80%	57%	72%	62%
Developmental Screening in the First Three Years of Life	81%	NR	Yes 89%	No 80%	NA	Yes 82%	No 75%	No 72%	No 59%

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

Note:
NA = Not Available. Insurers did not submit performance for the ACO/AE.
NR = Not Reported. The ACO/AE did not meet the minimum denominator size required for public reporting.
BCBSRI holds a commercial ACO contract with IHP and was unable to report quality performance for 2022 but has conveyed its intention to do so beginning with 2023 performance.

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, Prospect and Thundermist exceeded the 75th percentile for all the measures except one (*Controlling High Blood Pressure* or *HbA1c Control*). IHP and Integra exceeded the 75th percentile for three and four measures, respectively. All AEs exceeded the 75th percentile for *Follow-Up After Hospitalization for Mental Illness* and *Developmental Screening in the First Three Years of Life* (see Table 5.7).

Table 5.7: AE Medicaid Performance on the ACO Core Measure Set – 75th Percentile

Measure	Nat'l 75th PCTL	Above 75th Percentile?						
		BVCHC	COASTAL	INTEGRA	IHP	PCHC	PROSPECT	THUNDERMIST
Breast Cancer Screening	58%	Yes 64%	Yes 75%	Yes 64%	No 53%	Yes 69%	Yes 65%	Yes 58%
Colorectal Cancer Screening	NA	NA	NA	NA	NA	NA	NA	NA
Controlling High Blood Pressure	67%	No 59%	Yes 77%	Yes 70%	Yes 70%	Yes 68%	Yes 69%	No 60%
Eye Exam for Patients with Diabetes	59%	Yes 65%	Yes 66%	No 58%	No 55%	Yes 72%	Yes 61%	Yes 65%
Follow-Up After Hospitalizatn for Mental Illness (7-Day)	44%	Yes 49%	Yes 50%	Yes 51%	Yes 52%	Yes 55%	Yes 53%	Yes 46%
HbA1c Control (<8.0%)	57%	Yes 58%	Yes 59%	No 50%	No 55%	Yes 60%	No 50%	Yes 59%
Child and Adolescent Well-Care Visits (ages 12–21)	NA	42%	71%	63%	57%	46%	59%	50%
Developmental Screening in the First Three Years of Life	78%	Yes 93%	Yes 92%	Yes 81%	Yes 80%	Yes 84%	Yes 81%	Yes 81%

Source: OHIC analysis of quality performance data of Rhode Island Accountable Entities submitted by Rhode Island managed care plans to EOHHS and provided to OHIC by EOHHS.

Note:
NA = Not Available. Insurers did not submit performance for the ACO/AE.
Lifespan is not a contracted Medicaid Accountable Entity, and therefore is not included in this table.

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

None of the AEs exceeded the national 90th percentile for Medicaid performance for all the ACO Core Measure Set measures. PCHC exceeded the 90th percentile for all but one measure (*Controlling High Blood Pressure*). IHP did not exceed the 90th percentile for any measures. Only one AE (PCHC) exceeded the 90th percentile for *Hba1c Control* and only one AE (Coastal) exceeded the *Controlling high Blood Pressure*. All but one AE exceeded the 90th percentile for *Developmental Screening in the First Three Years of Life* (see Table 5.8).

Table 5.8: AE Medicaid Performance on the ACO Core Measure Set – 90th Percentile

Measure	Nat'l 90th PCTL	Above 90th Percentile?						
		BVCHC	COASTAL	INTEGRA	IHP	PCHC	PROSPECT	THUNDERMIST
Breast Cancer Screening	63%	Yes 64%	Yes 75%	Yes 64%	No 53%	Yes 69%	Yes 65%	No 58%
Colorectal Cancer Screening	NA	NA	NA	NA	NA	NA	NA	NA
Controlling High Blood Pressure	72%	No 59%	Yes 77%	No 70%	No 70%	No 68%	No 69%	No 60%
Eye Exam for Patients with Diabetes	63%	Yes 65%	Yes 66%	No 58%	No 55%	Yes 72%	No 61%	Yes 65%
Follow-Up After Hospitalization for Mental Illness (7-Day)	53%	No 49%	No 50%	No 51%	No 52%	Yes 55%	Yes 53%	No 46%
HbA1c Control (<8.0%)	60%	No 58%	No 59%	No 50%	No 55%	Yes 60%	No 50%	No 59%
Child and Adolescent Well-Care Visits (ages 12–21)	NA	42%	71%	63%	57%	46%	59%	50%
Developmental Screening in the First Three Years of Life	81%	Yes 93%	Yes 92%	Yes 81%	No 80%	Yes 84%	Yes 81%	Yes 81%

Source: OHIC analysis of quality performance data of Rhode Island Accountable Entities submitted by Rhode Island managed care plans to EOHHS and provided to OHIC by EOHHS.

Note:
NA = Not Available. Insurers did not submit performance for the ACO/AE.
Lifespan is not a contracted Medicaid Accountable Entity, and therefore is not included in this table.

Public Health and Health Equity Measure Set Performance

Public Health and Health Equity Measure Set and Target Values

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

- Adults without a Usual Source of Care
- Childhood Obesity Rate
- Fatal Overdoses
- Inadequate Prenatal Care
- Infant Mortality Rate
- Severe Maternal Morbidity

Each measure has either a total population target or a target focused on reducing a significant inequity in performance.

Baseline Performance on the Public Health and Health Equity Measure Set

Rhode Island has room for improvement on all six of the Public Health and Health Equity Measures. This is expected, as the OHIC-convened Public Health and Health Equity Target Measures Work Group selected the six measures during 2023 precisely for this reason. Inequities exist for the Hispanic population in *Adults without a Usual Source of Care, Childhood Obesity Rate*, and *Infant Mortality Rate*. Inequities exist for the Black population in the *Childhood Obesity Rate* and the *Infant Mortality Rate*. Finally, Rhode Island has room for improvement statewide on *Fatal Overdoes* and *Severe Maternal Morbidity* (see Table 5.9).

Table 5.9: Statewide Performance on the Public Health and Health Equity Measure Set

Measure	Population	Baseline Performance[10]	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[11]	<75.0 per 10,000 delivery hospitalizations

Source: *Childhood Obesity Rate* is sourced from the RI KIDS COUNT Factbook. *Fatal Overdoses* is sourced from the CDC State Unintentional Drug Overdoses Reporting System. *Adults without a Usual Source of Care* is sourced from the RI Foundation Health in RI Dashboard which uses Behavioral Risk Factor Surveillance System data. *Inadequate Prenatal Care* and *Infant Mortality Rate* are calculated using Vital Records Birth Certificate data analyzed by the Center for Health Data and Analysis, RI Department of Health. *Severe Maternal Morbidity* is calculated using Hospital Discharge Data analyzed by the Center for Health Data and Analysis, RI Department of Health.

10 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).

11 A comparable national figure for Severe Maternal Morbidity is not available for this time period.

Conclusion and Recommendations from the Health Insurance Commissioner

Total health care expenditures (THCE) per capita increased less than the cost growth target in 2022. This is a positive finding, as it represents the first time Rhode Island met the cost growth target without significant COVID-19 pandemic-specific factors influencing the result. Still, health care spending growth is expected to escalate in the future. To maintain access to affordable health care, Rhode Island must remain committed to strategies aimed at controlling health care spending growth while optimizing quality. These strategies include making essential investments in primary care and other community-based providers.

As Rhode Island measures health care spending growth and the factors that influence health care spending, it has become increasingly important to concurrently evaluate the financial performance and operating costs of health care providers, notably hospitals and hospital-based health systems. Health care spending is provider revenue and presently, there is no agency of record, or systematic accounting of Rhode Island provider financial performance and operating costs in the public domain. There are also opportunities to improve market oversight of transactions involving physician practices and practice groups.

Access, affordability, equity, and quality are key indicators of a high-performing health care system. To maximize these objectives, OHIC advances the following recommendations concerning policy and regulatory oversight. The recommendations do not touch on existing initiatives being led by other state agencies, such as the Certified Community Behavioral Health Clinics (CCBHCs) and health care workforce initiatives led by the Executive Office of Health and Human Services (EOHHS). These other state agency initiatives are critically important and will further promote access, affordability, equity, and quality.

Recommendation 1: Make Targeted Investments in Provider Capacity

Rhode Island will not meet the cost growth target over the long run without maximizing opportunities to treat patients in the most appropriate, lowest-cost setting, emphasizing primary care and community-based providers.

- Rhode Island payers should make targeted investments in primary care through a combination of increased reimbursement for primary care services when delivered at a primary care site of care, and increased funding for care management and practice infrastructure to support population-based care.
- Policymakers should implement the social and human service provider rate increases that are the product of the OHIC-led rate review on at least the planned three-year timeline.[1] These increases will boost Medicaid reimbursement for behavioral health, home and community-based services, and early intervention, among other service providers.
- Rhode Island should pursue other opportunities to secure federal funding for primary care and community-based providers. This includes participation in the new CMS States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model, which would pay participating primary care practices prospective, Medicare per beneficiary payment to fund advanced care management and behavioral health integration activities.

1 Rhode Island Office of the Health Insurance Commissioner. Social and Human Service Programs Review, September 1, 2023, available at: https://ohic.ri.gov/sites/g/files/xkgbur736/files/2023-09/Social%20and%20Human%20Service%20Programs%20Review%20-%20Final%20Report.pdf.

- Policymakers should also consider other investments in the primary care workforce, including provider training and loan forgiveness. Additional investments should also support behavioral health care integration into the primary care practice, where appropriate.

Recommendation 2: Maintain the Affordability Standards' Governance of Hospital Price Growth

OHIC's Affordability Standards governing commercial hospital price growth are essential to support achievement of the cost growth target and should be maintained. They have made health insurance and health care more affordable in Rhode Island, as demonstrated by a 2019 evaluation published in *Health Affairs* which concluded the following:

> "Relative to quarterly fee-for-service (FFS) spending among the control group, quarterly FFS spending among the Rhode Island group decreased by $76 per enrollee after implementation of the policy, or a decline of 8.1 percent from 2009 spending. Quarterly non-FFS primary care coordination spending increased by $21 per enrollee. Total spending growth decreased, driven by lower prices concordant with the adoption of price controls. Quality measures were unaffected or improved. The Rhode Island experience indicates that states may be able to slow total commercial health care spending growth through price controls while maintaining quality."[2]

Repealing the Affordability Standards will be detrimental to the affordability of health care for consumers, labor groups, and Rhode Island businesses.

Recommendation 3: Include More Consumer-focused Analyses in the Monitoring of Health Care System Performance

Consumers directly bear the burden of high and rising health care spending. When health care spending rises, consumers are forced to spend more of their income on out-of-pocket payments, such as deductibles, co-pays and co-insurance.

- OHIC should add a chapter to future annual reports that will assess and report on health care affordability with a focus on consumer impact.
- Information for future reporting should be derived from HealthSourceRI's biennial Health Information Survey, which is a household survey of Rhode Island residents on their experience getting care and use of medical services;[3] OHIC's annual health insurance rate review; administrative data sets with information on consumer out-of-pocket spending on health care; and other measures of consumer experience. To ensure alignment with Rhode Island's approach to health equity, data should be reported by race and ethnicity where feasible.

2 Baum A, Song Z, Landon BE, Phillips RS, Bitton A, Basu S. Health Care Spending Slowed After Rhode Island Applied Affordability Standards To Commercial Insurers. *Health Aff* (Millwood). 2019 Feb;38(2):237-245. doi: 10.1377/hlthaff.2018.05164. PMID: 30715981; PMCID: PMC6593124.

3 HealthSource RI, Surveys and Reports, accessed April 22, 2024, https://healthsourceri.com/surveys-and-reports

Recommendation 4: Improve State Oversight of the Health Care Delivery System

Oversight of the health care delivery system in Rhode Island needs additional investment. While OHIC has built the capacity to systematically collect, analyze, and interpret data on health care spending, there are opportunities for Rhode Island to develop capacity to garner deeper insights into the operation of the health care delivery system. This includes allocating resources to ongoing financial oversight of health care provider systems, including hospitals, large professional provider organizations, and nursing homes. Additional authorities and resources for the enhancement of market oversight should also be pursued.

- Rhode Island should create administrative capacity to collect, analyze, interpret, and publicly report data on provider finances and operating costs. To inform the creation of this capacity and any necessary statutory authority, Rhode Island should study models developed by other states. Two notable examples include the Hospital Reports Hub developed by the Colorado Department of Health Care Policy and Financing[4] and the Multi-Source Acute Hospital Financial Dataset maintained by the Massachusetts Center for Health Information and Analysis.[5]
- Physician practices and practice groups are increasingly the target of acquisition by larger hospital-based health systems, insurance companies, and private equity groups. Rhode Island's laws governing health care provider acquisitions and changes of ownership should be reviewed and potentially modified to require state notification and review of transactions involving physician practices and practice groups. This could include conducting cost and market impact reviews of transactions above a predefined market value threshold.

4 Colorado Department of Health Care Policy & Financing, Hospital Reports Hub, available at: **https://hcpf.colorado.gov/hospital-reports-hub**.
5 Massachusetts Center for Health Information and Analysis, *Multi-Source Acute Hospital Financial Dataset*, available at: **https://www.chiamass.gov/multi-source-acute-hospital-financial-dataset**.

Appendix

Appendix. Differences between TME and APCD Data Sources

Below are the key differences between the data submitted by insurers as part of the cost growth target data collection ("TME data"), and data from the All-Payer Claims Database.

Cost growth target data collection

- Used to calculate growth in health care costs over a given time period using aggregate data reported by insurers and public payers
- Data are aggregated and do not allow for claim-level analyses
- Includes data for both the commercial fully insured and self-insured lines of business
- Includes non-claims spending
- Includes estimated pharmacy spending for carve out groups
- Includes both medical and retail pharmacy rebates
- Includes insurer administration costs and profits

All-Payer Claims Database

- Used to study cost drivers and cost growth drivers to identify opportunities for cost growth mitigation
- Data are granular and allow for claim-level analyses
- Includes data for commercial fully insured, but only some of the self-insured (e.g., self-funded employers who opt in)
- Does not include non-claims spending
- Includes actual claims from pharmacy benefit managers
- Does not include any pharmacy rebates
- Does not include insurer administration costs and profits