Rhode Island Health Spending Accountability and Transparency Program

Steering Committee Meeting Minutes
EOHHS – Virks Building – 3 West Road, Cranston
April 19, 2024
9:30-11:00am

Steering Committee Attendees:
Cory King, Office of the Health Insurance Commissioner
Michele Lederberg, Blue Cross Blue Shield Rhode Island
Ed McGookin, Coastal Medical
Stephanie de Abreu (on behalf of Tim Archer), UnitedHealthcare
Al Charbonneau, Rhode Island Business Group on Health
Patrick Crowley, RI AFL-CIO
Peter Hollmann, Rhode Island Medical Society
Mark Jacobs
Teresa Paiva Weed, Hospital Association of Rhode Island
Dan Moynihan (on behalf of John Fernandez), Lifespan
Sam Salganik, Rhode Island Parent Information Network
Larry Warner, United Way
Erin Boles Welsh (on behalf of Kate Skouteris), Point32Health
Larry Wilson, The Wilson Organization

Absent:
David Cicilline, Rhode Island Foundation
Michael DiBiase, Rhode Island Public Expenditure Council
Pat Flanagan, CTC-RI
Diana Franchitto, Hope Health
Jim Loring, Amica Mutual Insurance Company
Peter Marino, Neighborhood Health Plan of Rhode Island
Michael Wagner, Care New England

I. Welcome

Cory King welcomed Steering Committee members to the April meeting and reviewed the agenda.

II. Approve Meeting Minutes

Michele Lederberg asked if Steering Committee members had any comments on the January 19th meeting minutes. The Steering Committee voted to approve the January meeting minutes with no opposition or abstentions.

III. New Public Health and Health Equity Strategy Work Group

Michael Bailit reminded everyone that the Steering Committee had previously recommended that a set of public health and health equity measures be monitored and reported alongside the cost growth target performance results. To that end, OHIC convened a Public Health and Health Equity (PH & HE) Measures Group, which recommended a set of six measure across four domains (child obesity, behavioral health, health care access, and maternal and infant health) for which baseline performance would be reported at the upcoming Cost Trends public forum. In terms of new activity on this front, Michael shared that over the remainder of the year, OHIC would convene a PH & HE Strategy Work Group whose goal would be to recommend at least one actionable strategy to improve performance on each of the PH & HE measures. Michael suggested that members emails Jessica Mar if they were interested in participating and noted that content expertise in one of the four domains would be helpful for these discussions.

- Sam Salganik mentioned that the discussion during the Strategy Work Group's first meeting included consideration of how the State's policy levers would shape the group's recommendation of a strategy to OHIC.
- Teresa Paiva Weed was concerned that hospitals would be held accountable for performance on some of these measures.
    - Michael noted that OHIC and the Work Group recognized that performance on these measures was influenced by upstream factors that were out of hospitals' control.
    - Sam Salganik added that just having measures and targets signaled that these areas were important to the State. The Work Group would ensure that its selected strategies were actionable.

IV. New Primary Care Spend Obligation

Cory King provided background information on OHIC's primary care expenditure target and the State's previous efforts with other states to define primary care. Through that process of working with other states, OHIC learned best practices to measure this crucial area of spending and to apply the same level of scrutiny of claims-based spending to non-claims-based spending (i.e., ensuring that payments made to Accountable Care Organizations (ACOs) for primary care activities actually made it to the primary care provider). He explained that this year, OHIC would update its primary care definition and reviewed these changes, which would occur in concert with the recommendations contained in OHIC's December report, *Primary Care in Rhode Island.*

- Teresa Paiva Weed asked how the primary care spending target would interact with the cost growth target and hospital rate cap.
    - Cory King replied that there was no tension between the cost growth target and OHIC's Affordability Standards. The hospital rate cap and Standards were tools that helped the State achieve the cost growth target. However, he noted that adherence to a cost growth target did not mean the State should not increase expenditures in certain areas of the health care system – doing so was necessary in the case of primary care. Additionally, he alluded to the upcoming substantial Medicaid rate increases due to the state's receipt of state-directed payments from CMS. He noted that in the future, it would be important to contextualize performance against the cost growth target with these payments. OHIC now had the function to review Medicaid rates, and he envisioned OHIC would add reviewing primary care reimbursement rates to this scope.

- Dan Moynihan asked about the minimum floor for Patient-Centered Medical Home (PCMH) infrastructure payments for practices.
    - Cory replied that a floor did not exist and that he was interested to hear from providers on whether the regulatory payments for recognized PCMHs were sufficient.
- Stephanie de Abreu asked whether obstetricians and gynecologists (OB/GYNs) would be included in the definition of a primary care provider in the new definition.
    - Michael Bailit responded that they would not be included. OHIC's decision to exclude these practitioners from the definition was based on common practice across most states. However, he recognized that both sides of the argument were valid; OB/GYNs often functioned as primary care physicians for pregnant individuals, but at the same time, they did not provide comprehensive and longitudinal primary care.
    - Teresa Paiva Weed asked whether OHIC could analyze the impact of including OB/GYNs in the definition of primary care.
    - Cory King agreed that this was worth examining and added that any changes to the definition would go through the formal rulemaking process.
- Sam Salganik asked why the target was limited to the fully insured population only, and what the level of investment in primary care has been like in recent years.
    - Cory responded that OHIC's authority was limited to the fully insured market so the target could only apply to that segment. The previous definition, established by Chris Koller, who served Rhode Island as the country's first health insurance commissioner, included payments that could not be separated between the fully insured and self-insured market segments as a way to get multi-payer engagement in this work. However, Cory wanted to utilize the target to drive investments in primary care capitation and reimbursement. To Sam's second question, Cory replied that the primary care target was structured so that there would be incremental increases in investment over five years, with spending on "direct"[1] primary care capped at 9.7 percent.

V. New Behavioral Health Spend Obligation

Cory noted that OHIC promulgated changes to its Powers and Duties and now had the ability to establish expenditure targets for behavioral health services. The coronavirus pandemic had laid bare the state of emergency for children and adolescent's behavioral health needs. The updated regulation included a requirement for payers to increase baseline expenditures (defined as calendar year 2022 spending) by 200% by 2025 for community-based behavioral health care for fully insured children and adolescents. A data collection template and Implementation Manual, which would include specifications on how to report on this spending, would be released this summer. Cory noted that OHIC eventually wanted to extract these data

[1] OHIC currently defines "direct primary care" as the sum of all claims-based and non-claims-based primary care payments exclude HIE payments for CurrentCare and PCMH administration payments to support the operations of CTC-RI. For more information, see the Rhode Island Health Care Cost Growth Target and Primary Care Spend Obligation Implementation Manual: 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

from the All-Payer Claims Database (APCD), but wanted to go through one reporting cycle with the payers first.

- Sam expressed his support for a spending target for children's behavioral health. He noted that this was one area that was ripe for coordination with Medicaid for children, as Medicaid was the largest payer for children's behavioral health. There was a decades-long lack of investment in this area.
- Larry Wilson asked whether the spending target could be extended to adults in the future. Cory replied that OHIC would consider that for the future.

VI. Effectiveness of OHIC's Affordability Standards

Michael Bailit highlighted the successes of the Standards in Rhode Island with three examples; in one instance, he referenced the State's high ranking in the Commonwealth Fund's reputable State Scorecard. He noted RI has received national recognition for its work on health care affordability and other states sought to emulate its policies. Cory noted that there were two bills pending in the General Assembly that would repeal tenets of OHIC's Affordability Standards. One of the bills would tether RI providers' reimbursements to those of providers in neighboring states (i.e., Connecticut and Massachusetts) whose economies produce higher health insurance premiums. He alluded to the fact that legislators in Massachusetts constantly raised that health care in their state was not affordable, so it did not make sense to use those data as a reference.

- Mark Jacobs noted that one reason to increase provider reimbursement in the state was to make recruitment of doctors in RI more competitive. Additionally, the presence of two large health systems – Massachusetts General Brigham and Beth Israel Lahey Health – drew a lot of talent to the state.
- Cory agreed that that was a fair point but argued that there needed to be a more intensive study in the State on the differences in reimbursement across states. He added that the cost of living was very different across the states, so these conversations were nuanced. Primary care was also an area where there were stark differences in reimbursement across the states.
- Ed McGookin shared that he often cited RI's high ranking by the Commonwealth Fund's scorecard, but also noted that primary care providers found the State a less attractive place to practice and live because of the large disparities in salary compared to MA and CT.
- Sam Salganik suggested that participants read the Rhode Island Foundation's report on the financial performance and structure of the State's hospitals and health systems, as it provided a lot of nuanced and useful information on hospital costs in CT, MA, and RI.
- Stephanie de Abreu noted that some costs in the system stemmed from people not utilizing primary care.

Cory announced that Rhode Island was applying for Cohort 3 of the Center for Medicare and Medicaid Innovation's (CMMI's) AHEAD[2] model and that the application was due in August. Should RI be selected, the State would have a pre-implementation period of two years, after which point the State would need a few hospitals to participate and at least one commercial payer. Cory noted that if the State was unsuccessful in those recruitment efforts, it would cease its participation in the Model. He said that he suspected that CMMI would not release other

[2] "States Advancing All-Payer Health Equity Approaches and Development"

initiatives that were primary care-driven in the near future, so this was the State's best shot at increased investment in primary care that was supported at the federal level. Cory shared that four states (CT, HI, MD, and VT), to his knowledge, had applied for the Model so far.

- Teresa Paiva Weed noted that under the AHEAD model, money would go from hospitals to primary care practices, and that hospitals would not be willing to participate unless Medicaid funding worked out.
- Mark Jacobs confirmed that the Notice of Funding Opportunity (NOFO) for the AHEAD model stated that savings from hospital global budgets would fund primary care activities. He added that he did not think that the minimal Enhanced Primary Care Payments (EPCPs) would draw a lot of excitement for Primary Care AHEAD.

VII. APCD Cost Driver Analyses: Understanding Inpatient Hospital Spending Trends

Michael Bailit noted that OHIC now possessed the data tools to perform deep dives into cost drivers using data from the APCD, and turned to an example of inpatient hospital spending to illustrate this point. The Overview dashboard on the OHIC Data Hub showed that service unit payments for inpatient hospital services decreased in 2021 and 2022, which was unusual. He explained that OHIC's data tools revealed three contributing factors to the decrease in service unit payments for this spending category: 1) the movement of joint replacement surgeries (which had very high unit payments) from an inpatient to an outpatient setting; 2) decreases in admissions for major respiratory infections and inflammations, and 3) decreases in utilization of tracheostomies and transplants.

VIII. Public Comment

- Elena Nicolella (RIHCA) recognized the concerns raised about the AHEAD model but encouraged participants to be open to submitting an application. The State might walk away in the future, but AHEAD was a pathway to get Medicare invested in the State's programs.

IX. Next Steps and Wrap-Up

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