

# Rhode Island Health Care Cost Trends Steering Committee

May 17, 2021



# Agenda

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1. Welcome
2. Approval of meeting minutes
3. Implications of 2019 cost trends results for future action
4. Methodological challenges with reporting 2019 performance at the insurer and ACO/AE levels
5. Cost driver analyses: 2019 hospital outpatient and other professional spending
6. Value-based payment (VBP) subcommittee
7. Low-value care
8. Informational updates
9. Public comment
10. Next steps and wrap-up

Welcome

# Approval of Meeting Minutes

# Approval of Meeting Minutes

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- In advance of the meeting, project staff shared minutes from the April 29<sup>th</sup> Steering Committee meeting.
- **Does the Steering Committee wish to approve the April meeting minutes?**

# Implications of 2019 Cost Trends Results For Future Action

# Implications of 2019 Cost Trends Results for Future Action

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- **How do Steering Committee members think the Cost Trends Project should respond to the 2019 performance results showing that the state exceeded the cost growth target?**
- Recent and current actions of the Steering Committee include:
  - Deeper analyses of pharmacy costs and cost growth and recommendation to Governor McKee to pursue pharmacy price legislation
  - Creation of a VBP Subcommittee to develop strategies to accelerate adoption of advanced VBP models
  - Deeper analyses of hospital outpatient and other professional spending (*to be presented during today's meeting*)

# Methodological Challenges with Reporting 2019 Performance at the Insurer and ACO/AE Levels



# Methodological Challenges

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- First-year cost trends performance analysis experience revealed the extent of the impact of *high-cost outliers* and *changes in risk scores* on cost trends performance when assessed at the insurer and ACO/AE levels.
- Because reporting performance results is performed, in part, for accountability purposes, we want to be sure we are appropriately accounting for and acknowledging the impact of those factors.
  - This was the reason for not sharing performance at the insurer and provider entity levels during the April meeting.
- **During the June Steering Committee meeting, we will discuss proposed changes to the performance analysis methodology for next year's report.**

# Cost Driver Analyses: Other Professional and Hospital Outpatient Spending

# Agenda

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1. Other professional spending
2. Hospital outpatient (HOPD) spending
3. Conclusions

# Other Health Professional Spending

# Methods

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1. Other professional spending identified using BETOS
  - BETOS was developed 30 years ago to classify CPT codes in the Medicare Physician Fee Schedule, and was recently updated
  - Standardized approach to classifying professional spending
  - Details in APPENDIX
2. Other Health Professionals category is what we examine.
3. For several reasons, our findings would not be expected to be identical to Bailit team approach (i.e., what payers were asked to report)
4. Largest dollar amounts were for NPs, PAs and Clinical Psychologists, and virtually all of their spending was in E&M codes

# APCD: Total Paid Claims

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|                           | <b>2018</b>   | <b>2019</b>   |
|---------------------------|---------------|---------------|
| Total Paid Claims         | \$6.9B        | \$6.4B        |
| Commercial (% of total)   | \$1.64B (24%) | \$1.61B (25%) |
| Medicaid MCO (% of total) | \$1.31B (19%) | \$1.47B (25%) |

# APCD: Total and Professional Claims, 2018-2019

|                        | 2018        | 2019        | % Increase |
|------------------------|-------------|-------------|------------|
| Total Paid Claims (\$) | \$6.9B      | \$6.4B      |            |
| Commercial             |             |             |            |
| Total Paid Claims (\$) | \$1.64B     | \$1.61B     |            |
| Professional (\$)      | \$486M      | \$477M      |            |
| Professional (PMPM)    | \$150       | \$156       | 4%         |
| Medicaid MCO           |             |             |            |
| Total Paid Claims (\$) | 1.31B (19%) | 1.47B (25%) |            |
| Professional (\$)      | \$365M      | \$410M      |            |
| Professional (PMPM)    | \$126       | \$145       | 15%        |

It is important to look at per person per month (PMPM) spending, which adjusts for year-to-year changes in numbers of patients. Professional spending increased in both Commercial and Medicaid from 2018 to 2019.

# APCD: Other Professional Claims, 2018-2019

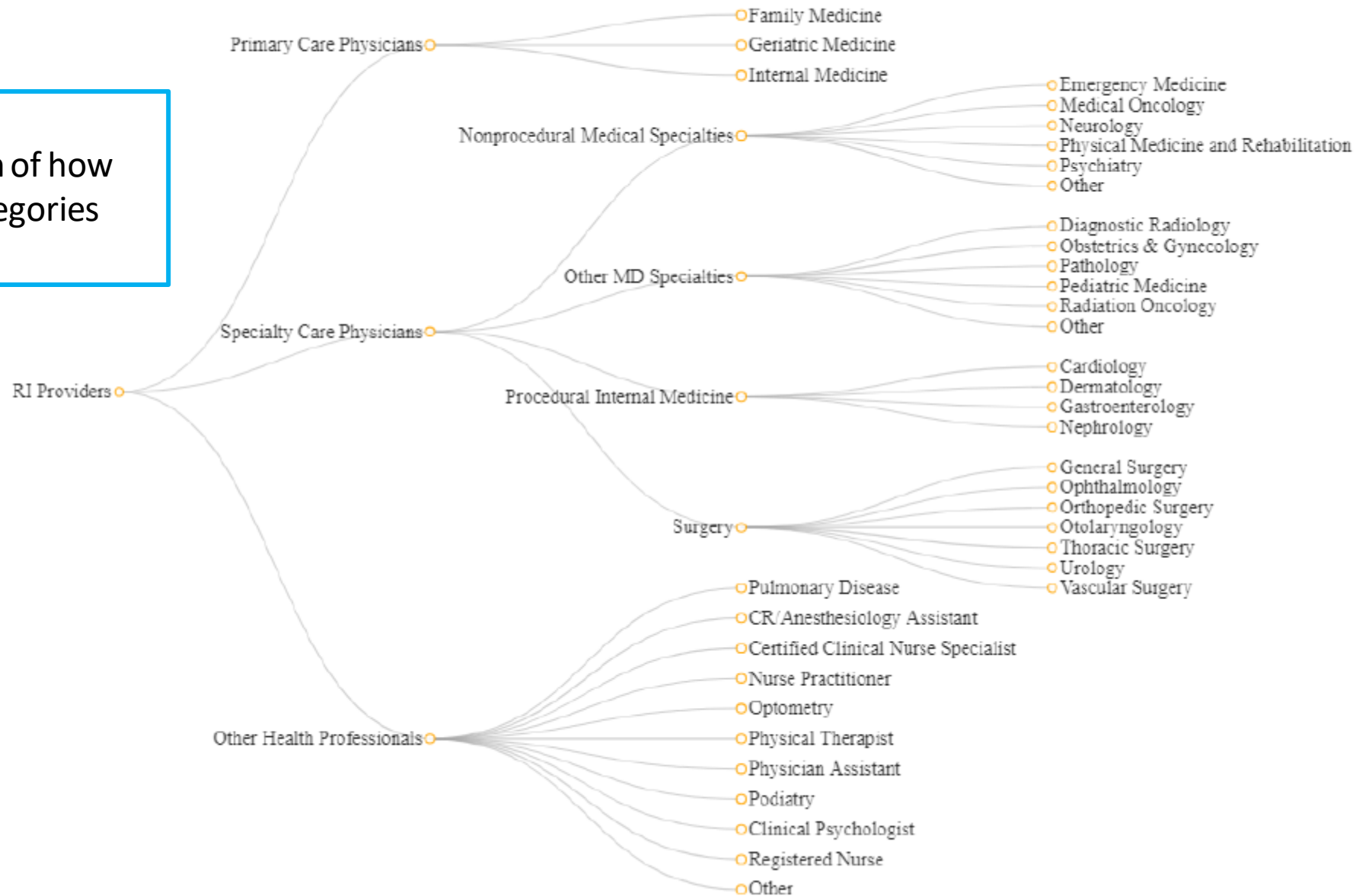
|                           | 2018        | 2019        | % Increase |
|---------------------------|-------------|-------------|------------|
| Total Paid Claims         | \$6.9B      | \$6.4B      |            |
| Commercial                |             |             |            |
| Total Paid Claims         | \$1.64B     | \$1.61B     |            |
| Professional (\$)         | \$486M      | \$477M      |            |
| Professional (PMPM)       | \$150       | \$156       | 4%         |
| Primary Care              | \$15        | \$16        | 3%         |
| Other Professional (PMPM) | \$35        | \$39        | 9%         |
| Medicaid MCO              |             |             |            |
| Total Paid Claims         | 1.31B (19%) | 1.47B (25%) |            |
| Professional (\$)         | \$365M      | \$410M      |            |
| Professional (PMPM)       | \$126       | \$145       | 15%        |
| Primary Care              | \$8.8       | \$9.1       | 3%         |
| Other Professional (PMPM) | \$33        | \$33        | -1%        |

In the APCD data, Other Professional spending increased in Commercial but not in Medicaid, from 2018 to 2019. Note that Primary Care spending increased by only 3% in both Commercial and Medicaid.

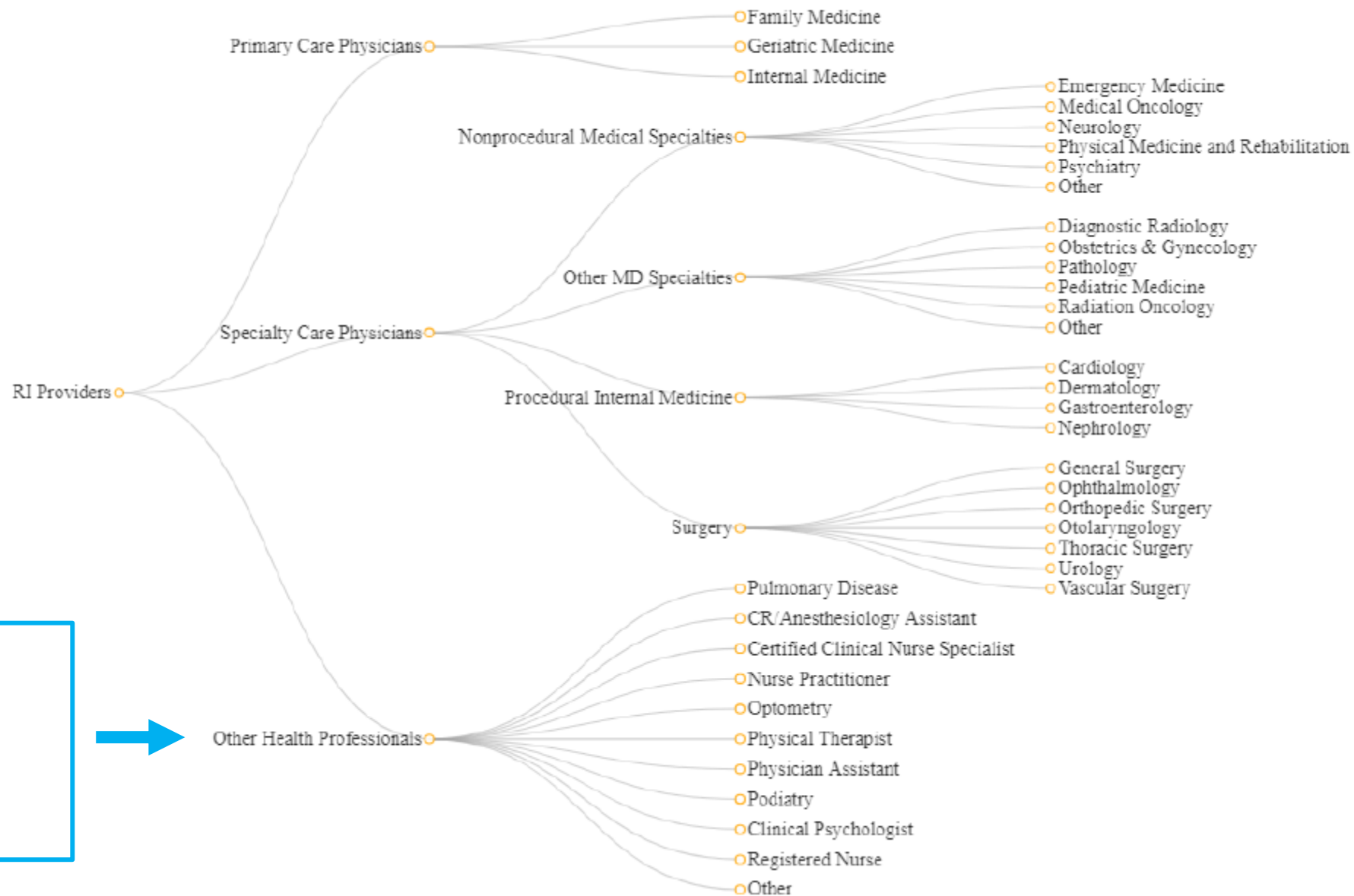


# BETOS Classification System

This is a visual representation of how the BETOS categories work.



# BETOS Classification System



Our analyses focused on the Other Health Professionals category

# BETOS: Other Health Professionals, 14 types

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CRNA/Anesthesiology Assistant  
Certified Clinical Nurse Specialist  
Chiropractic  
Midwife  
Nurse Practitioner  
Optometry  
Other (Counselor, includes dentist)

Physical Therapist  
Physician Assistant  
Podiatry  
Psychologist, Clinical  
Registered Nurse  
Social Worker  
Specialist

# BETOS: Other Health Professionals

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CRNA/Anesthesiology Assistant  
Certified Clinical Nurse Specialist  
Chiropractic  
Midwife  
**Nurse Practitioner**  
Optometry  
**Other (Counselor, includes dentist)**

Physical Therapist  
**Physician Assistant**  
Podiatry  
Psychologist, Clinical  
Registered Nurse  
Social Worker  
Specialist

The largest spending amounts were in NP, Other, and PA groups, and our analysis therefore focuses on these 3 groups.

# Commercial: Claim level Volume and Price Changes

## Changes: 2018-2019

| Commercial                     | # Claims | Price |
|--------------------------------|----------|-------|
| NP                             |          |       |
| 99213 (Office Visit, 15 mins.) | 16%      | 3%    |
| 99214 (Office Visit, 25 mins.) | 10%      | 3%    |
| Counselor                      |          |       |
| 90834 (Psychotherapy)          | 19%      | 0%    |
| PA                             |          |       |
| 99213 (Office Visit, 15 mins.) | 4%       | 2%    |
| 99214 (Office Visit, 25 mins.) | 7%       | 0%    |

In the Commercial group, there were large 1-year increases in the number of claims (4-19%), and small increases in prices (0 to 3%). Spending increases were due to increases in volume.

# Medicaid: Claim level Volume and Price Changes

## Changes: 2018-2019

| Medicaid              | # Claims | Price |
|-----------------------|----------|-------|
| NP                    |          |       |
| 99213                 | 28%      | -2%   |
| 99214                 | 26%      | 1%    |
| Counselor             |          |       |
| 90834 (Psychotherapy) | 36%      | 13%   |
| PA                    |          |       |
| 99213                 | 16%      | 2%    |
| 99214                 | 8%       | -2%   |

In the Medicaid group, there were large 1-year increases in the number of claims (8% to 36%), and smaller increases in prices (-2 to 13%). Spending increases were due to increases in volume. For Medicaid, the Other Health Professional category was flat overall because these increases were counterbalanced by decreases in an “other” category that we are still investigating.

# Context for NP, Counselor & PA Data

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1. Remember that Primary Care spending for both Commercial and Medicaid is increasing at 3%
2. The PMPM spending for NP, Counselor and PA is approximately the same as Primary Care spending
3. This suggests that the observed increases in NP, Counselor and PA volumes represent new services
4. We cannot determine whether the NP and PA services are in primary care or specialty settings

# Hospital Outpatient Department Spending

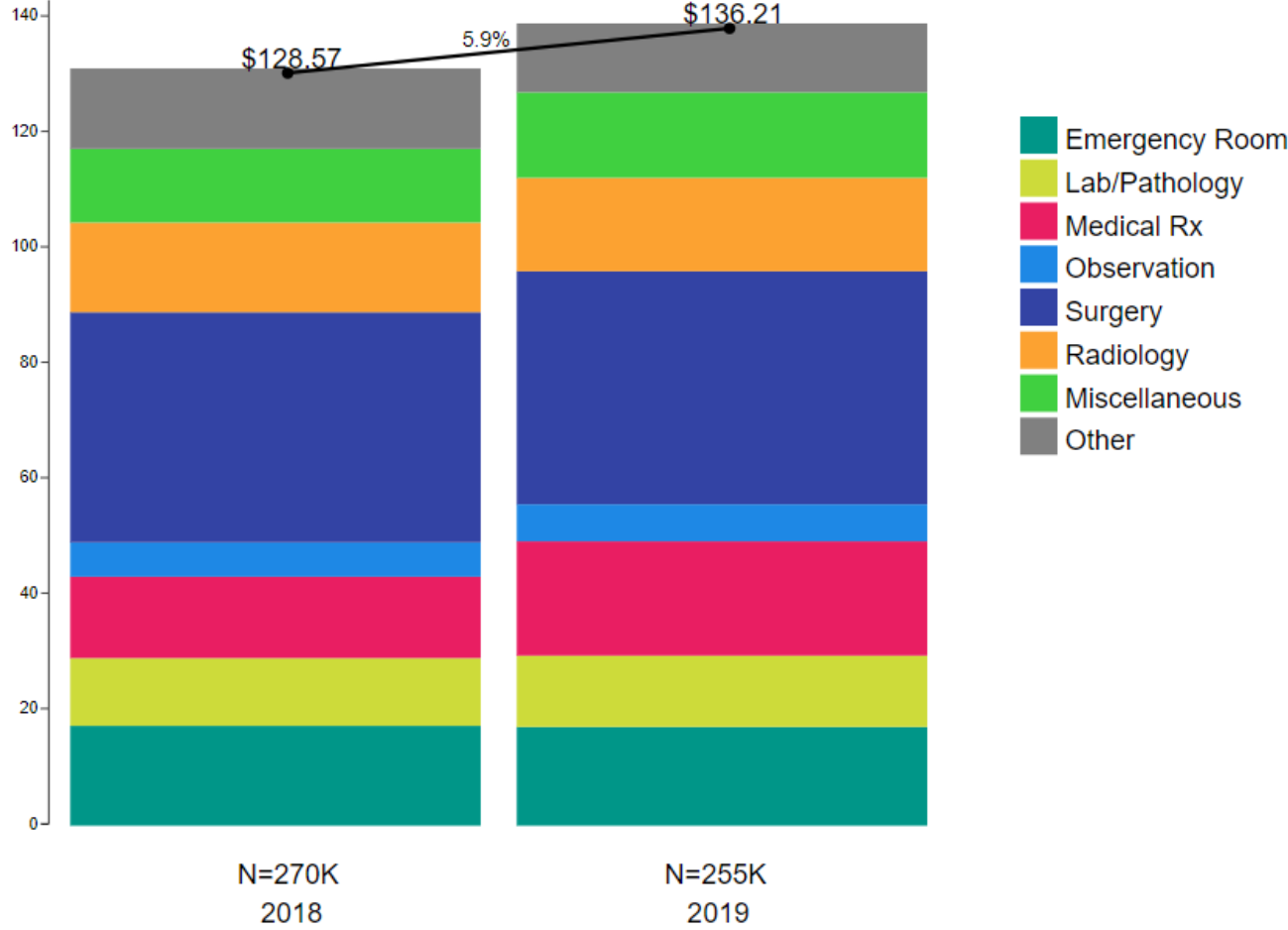


# Hospital Outpatient Department spending

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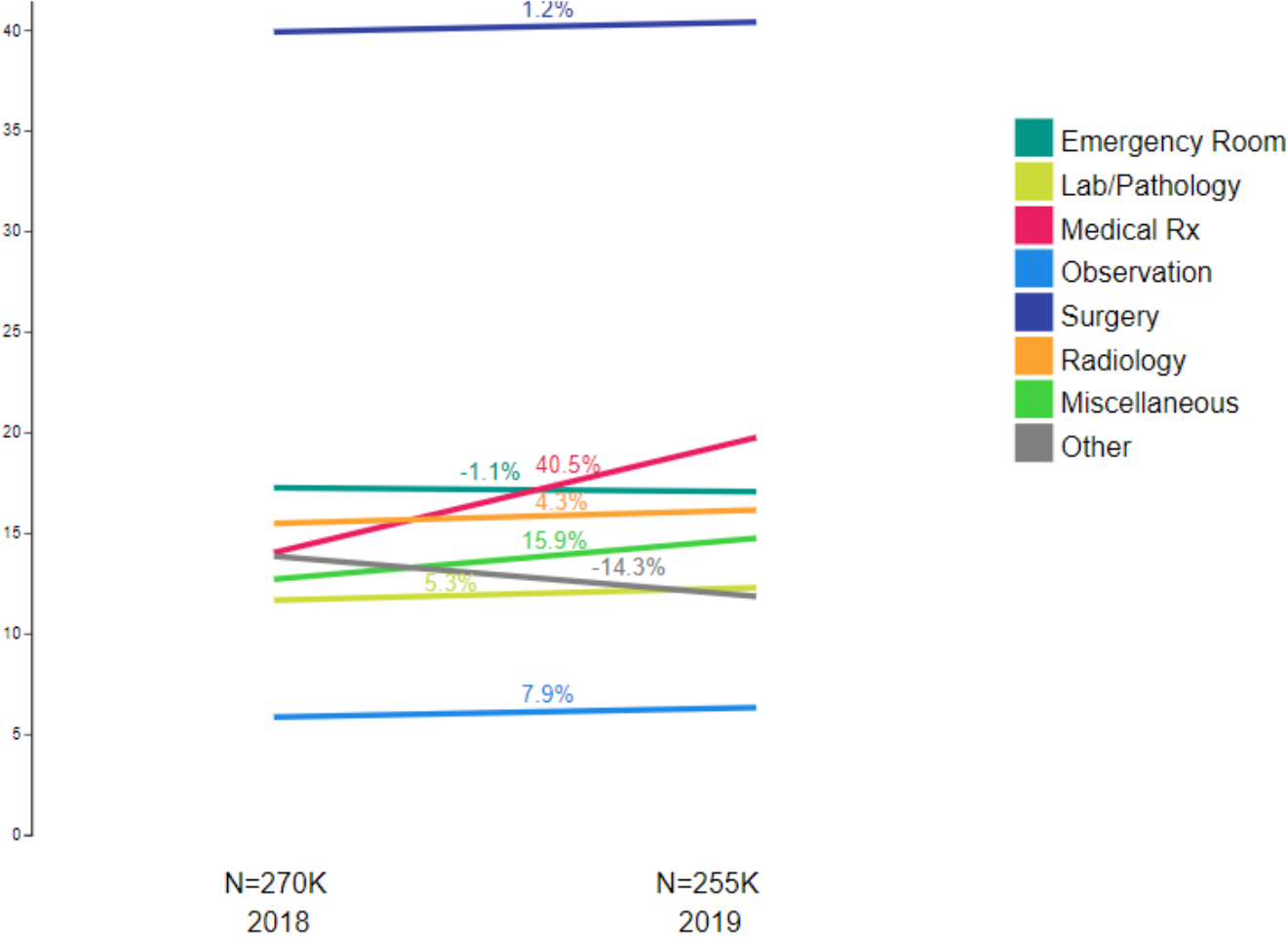
1. The Health Care Cost Institute (HCCI) classifies spending in four groups
  - Inpatient – facility payments for inpatient admissions
  - Outpatient – facility payments for outpatient visits and procedures
  - Professional – payments for professional services (inpatient and outpatient)
  - Pharmacy – payments for drugs from retail pharmacies
2. Facility fee: can be charted for the use of hospital facilities and equipment
3. We examined Outpatient spending, and Professional spending that we could identify as occurring in hospital outpatient departments (there is a HOPD “place of service” code)
4. Both Outpatient and Professional spending have subcategories defined by the HCCI methods
5. We did not examine specific codes within these subcategories

# Commercial Outpatient Spending (PMPM)



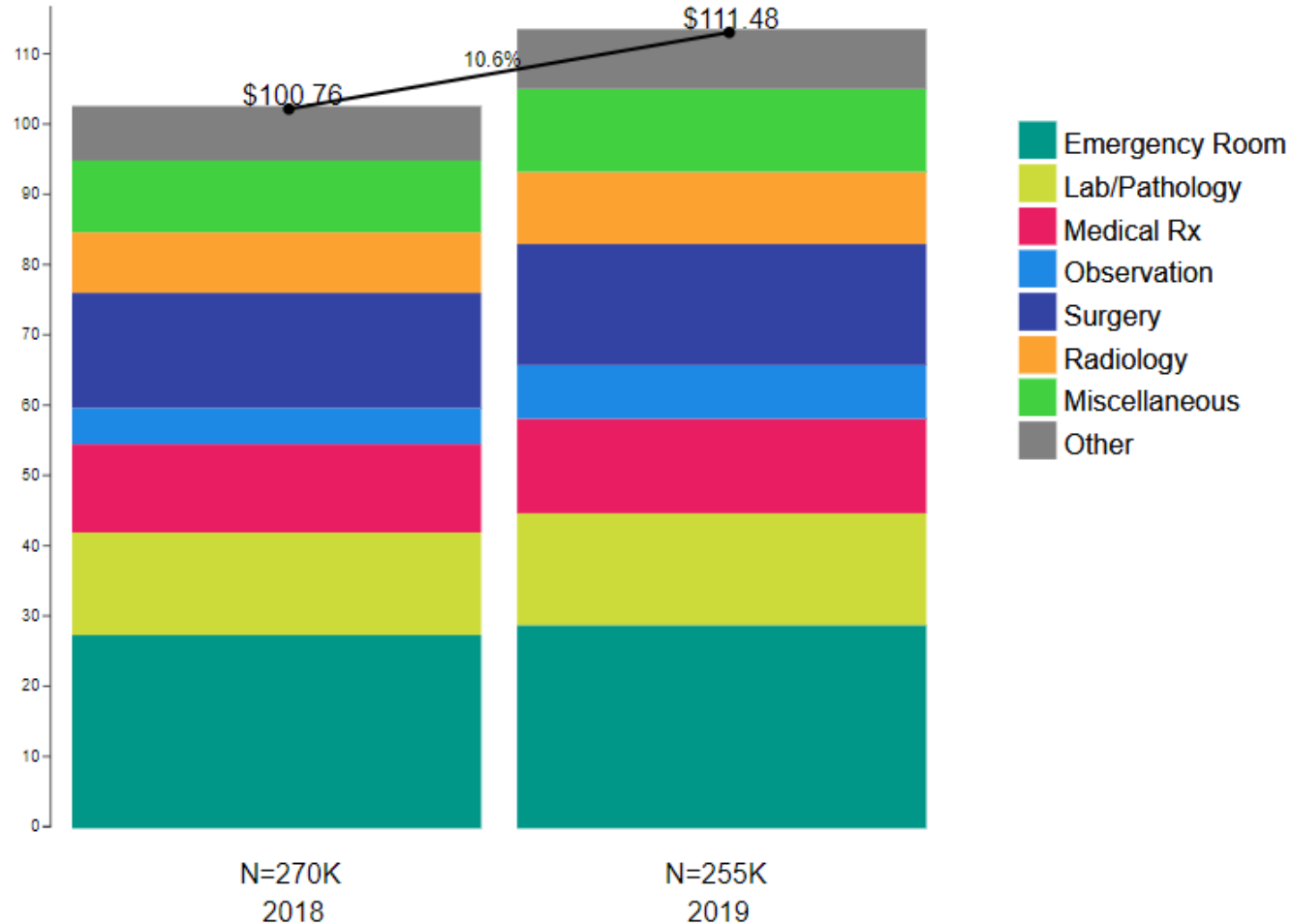
Commercial outpatient spending (which mostly consists of non-inpatient facility costs), increased by 5.9% from 2018-2019.

# Commercial Outpatient Subgroups (PMPM)



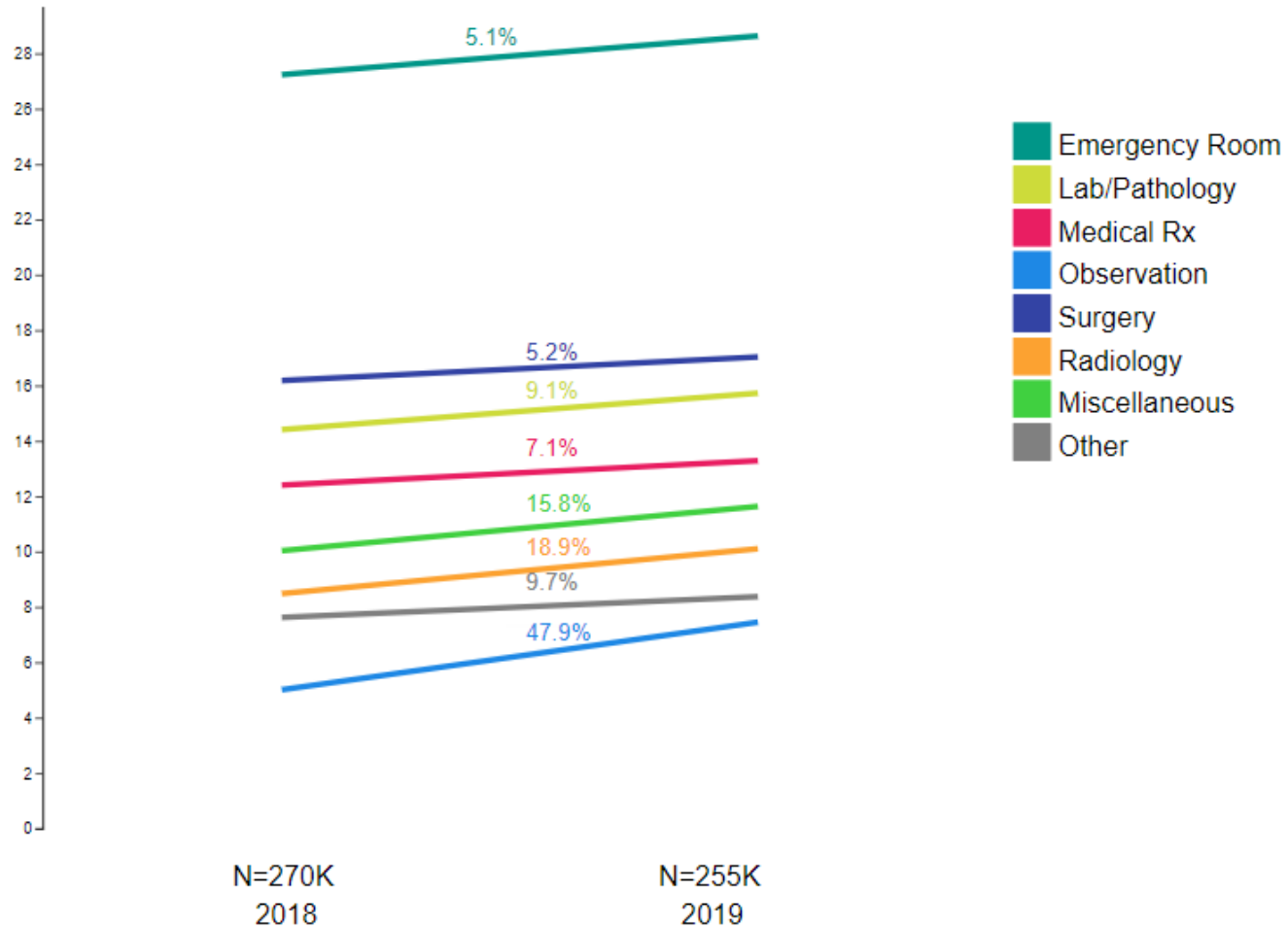
The largest year over year changes (40%) were seen in the Medical Rx group. There was also a 15.9% increase in the Miscellaneous group, which we are investigating.

# Medicaid Outpatient Spending (PMPM)



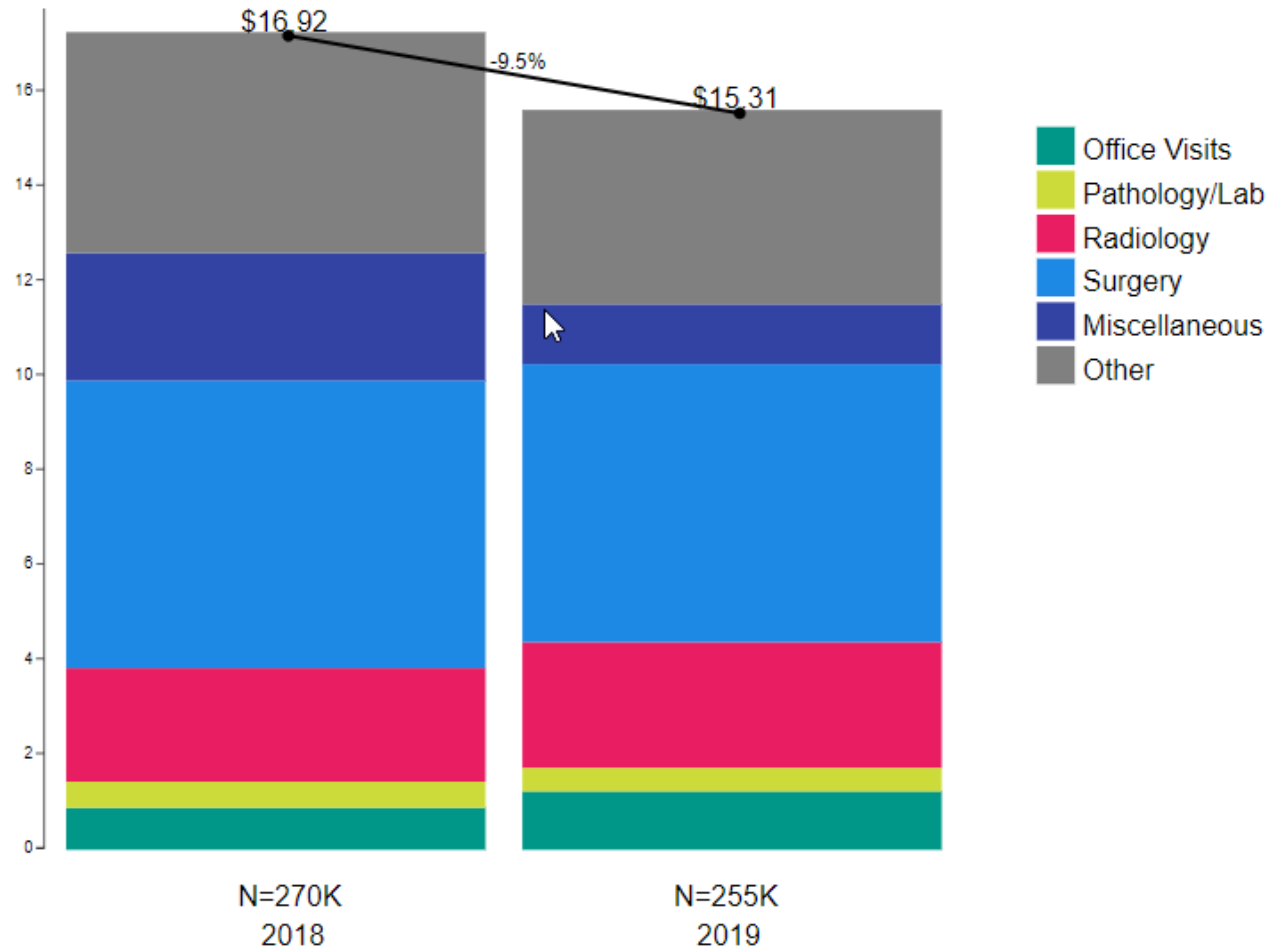
Medicaid outpatient spending (which mostly consists of HOPD facility costs), increased by 10.6% from 2018-2019.

# Medicaid Outpatient Subgroups (PMPPM)



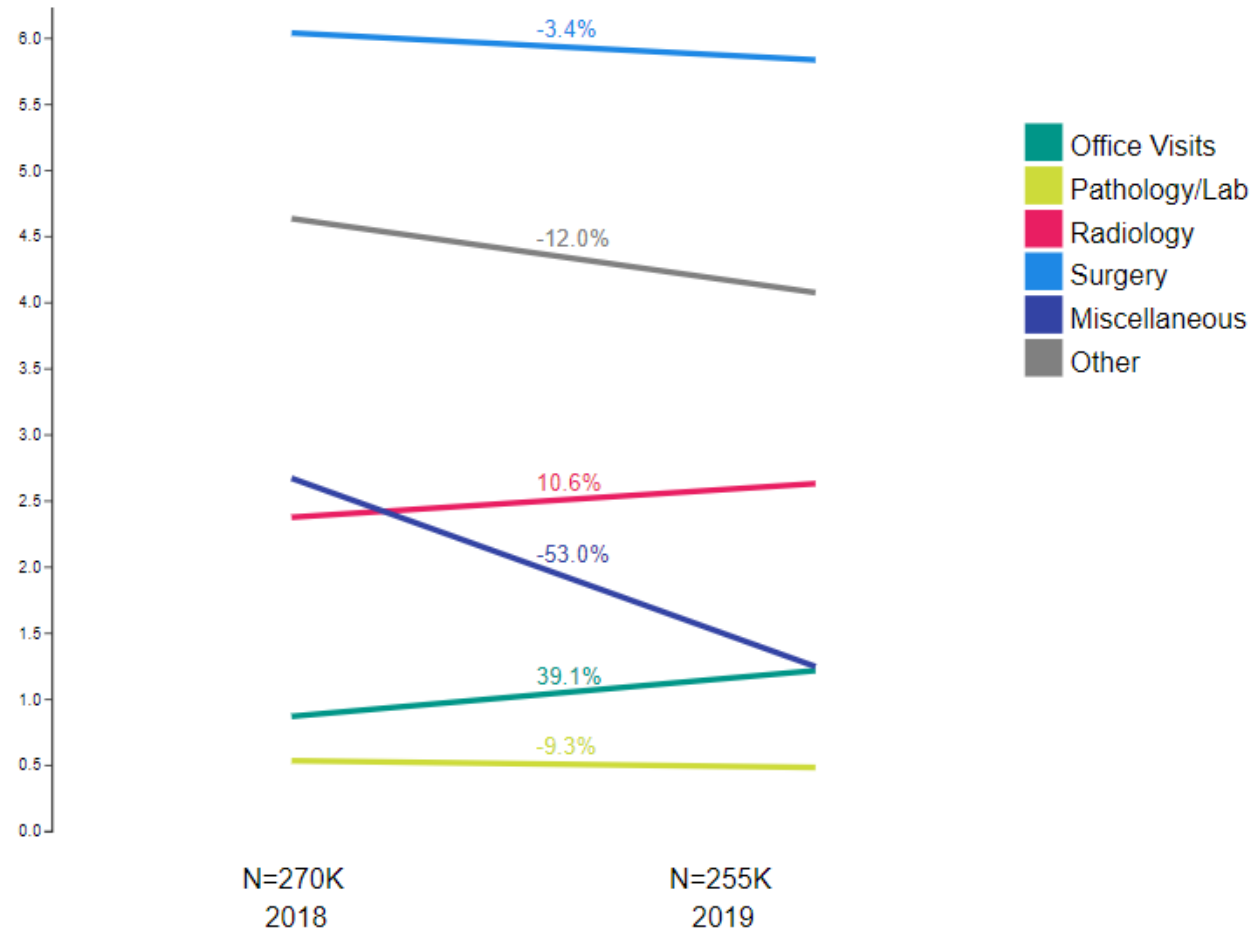
There were increases in every subgroup, ranging from 5.1% for Emergency Room to 47.9% in Observation.

# Commercial Professional Spending in HOPD Setting (PMPM)



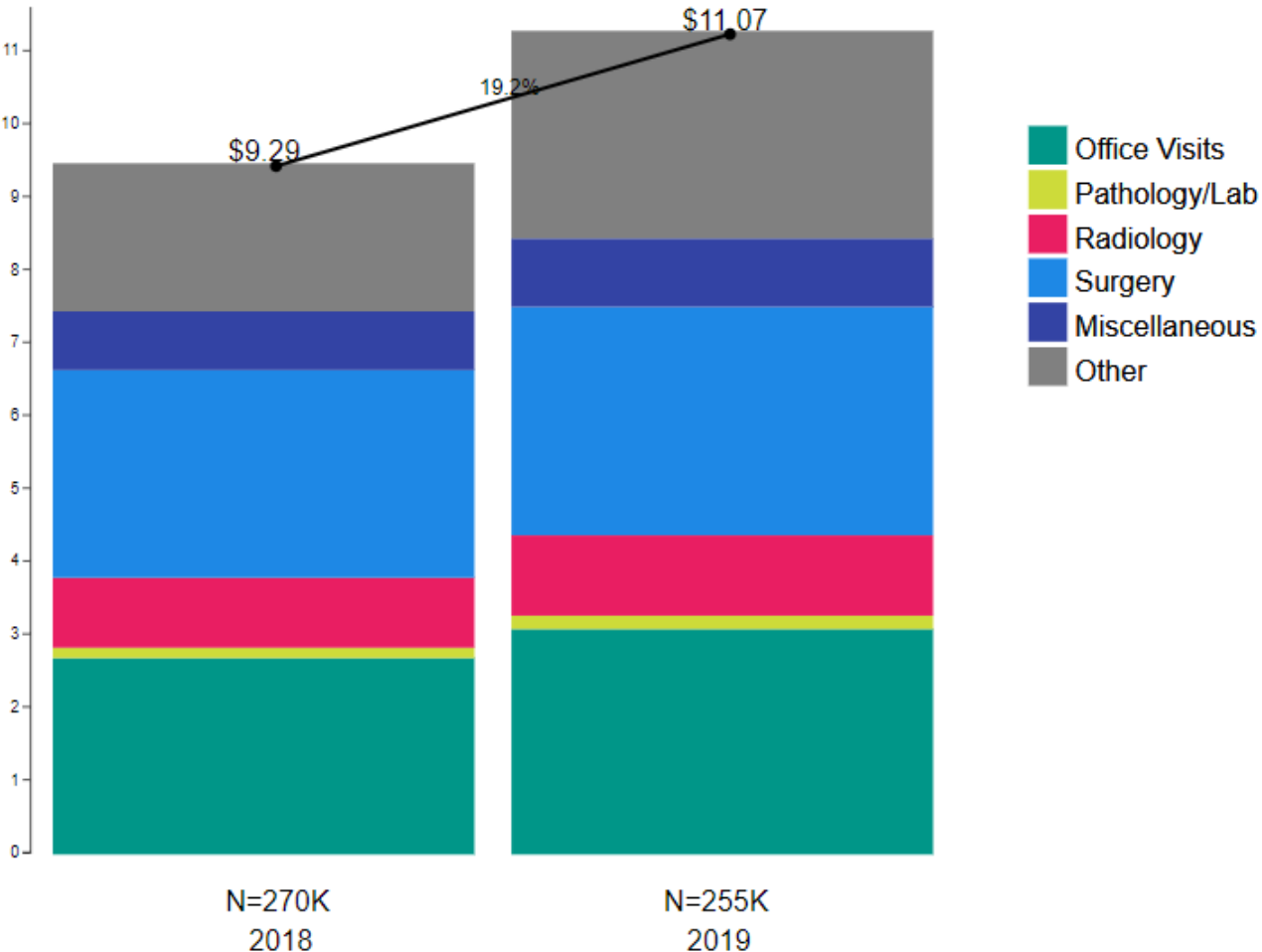
Commercial professional HOPD spending decreased by 9.5%. Again, note that these PMPMs are about 15% of the outpatient spending numbers.

# Subgroups of Commercial Professional Spending in HOPD Setting (PMPM)



Decreases in Surgery, Other, and Miscellaneous subgroups were mostly responsible for the decreases in Commercial professional HOPD spending. (We did not prioritize a deeper dive on these subgroups because compared with the Outpatient spending increases they were quite small).

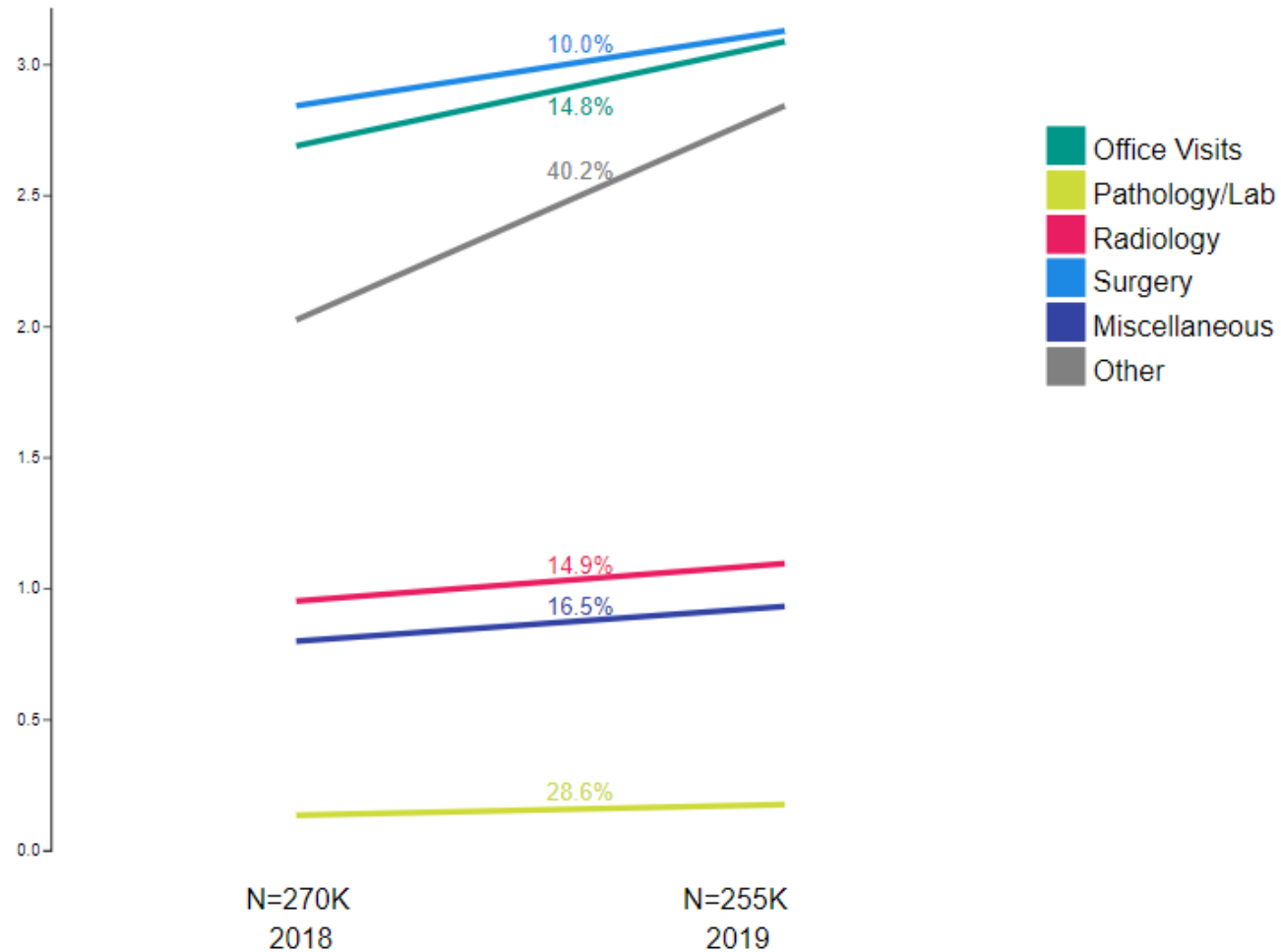
# Medicaid Professional Spending in HOPD Setting (PMPM)



Medicaid professional HOPD spending increased by 19.2%. Note that the PMPM here is about 10% of the outpatient HOPD spending.



# Subgroups of Medicaid Professional Spending in HOPD Setting (PMPPM)



There were increases in all subcategories, including 10% for surgery, 14% for office visits, and 40% for Other (which we are investigating).

# Conclusions

# Conclusions

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1. For both Commercial and Medicaid, increases in Other Health Professional spending were mostly due to increases in the number of office visits to NPs, mental health Counsellors, and PAs (not due to price increases)
2. Remembering that HOPD spending is in 2 categories, (1) outpatient costs (hospital outpatient facility spending) and (2) Professional spending that occurs in HOPD settings
  - For both Commercial and Medicaid, most of the HOPD costs, and most of the cost increases, were due to outpatient costs (hospital outpatient facility spending)
  - For Commercial, the biggest increase (40.5%) was in Medical Rx (see next slide)
  - For Medicaid, there were increases in all subcategories
  - We have not yet done volume vs. price analyses of these outpatient costs

1. J codes cost in outpatient facility claims, top 10 total paid measure j codes.

| 2018               |   |                |                        | 2019               |   |                |                        |
|--------------------|---|----------------|------------------------|--------------------|---|----------------|------------------------|
| Procedu<br>re_Code | Long_Desc   | # of<br>claims | total_paid_me<br>asure | Procedu<br>re_Code | Long_Desc   | # of<br>claims | total_paid_me<br>asure |
| J1745              | INJECTION<br>INFLIXIMAB<br>EXCLUDES<br>BIOSIMILAR 10 MG | 1183           | \$ 5,407,436           | J9271              | INJECTION<br>PEMBROLIZUMAB 1<br>MG                      | 444            | \$ 5,979,067           |
| J9355              | INJECTION<br>TRASTUZUMAB 10<br>MG                       | 902            | \$ 3,989,488           | J1745              | INJECTION<br>INFLIXIMAB<br>EXCLUDES<br>BIOSIMILAR 10 MG | 1092           | \$ 5,207,570           |
| J2505              | INJECTION<br>PEGFILGRASTIM 6<br>MG                      | 564            | \$ 3,208,172           | J9355              | INJECTION<br>TRASTUZUMAB 10<br>MG                       | 868            | \$ 3,713,079           |
| J9310              | INJECTION<br>RITUXIMAB 100 MG                           | 349            | \$ 2,963,976           | J9035              | INJECTION<br>BEVACIZUMAB 10<br>MG                       | 455            | \$ 3,500,414           |
| J9271              | INJECTION<br>PEMBROLIZUMAB 1<br>MG                      | 204            | \$ 2,482,799           | J9312              | INJECTION<br>RITUXIMAB 10 MG                            | 362            | \$ 3,372,159           |
| J9035              | INJECTION<br>BEVACIZUMAB 10<br>MG                       | 435            | \$ 2,061,931           | J9299              | INJECTION<br>NIVOLUMAB 1 MG                             | 276            | \$ 3,362,435           |
| J9299              | INJECTION<br>NIVOLUMAB 1 MG                             | 251            | \$ 2,036,721           | J2505              | INJECTION<br>PEGFILGRASTIM 6<br>MG                      | 446            | \$ 3,138,164           |
| J1569              | INJ IG GAMMAGARD<br>LIQ IV<br>NONLYOPHILIZED<br>500 MG  | 534            | \$ 1,374,441           | J3380              | INJECTION<br>VEDOLIZUMAB 1 MG                           | 250            | \$ 1,896,480           |
| J3380              | INJECTION<br>VEDOLIZUMAB 1 MG                           | 201            | \$ 1,131,120           | J2350              | INJECTION<br>OCRELIZUMAB 1 MG                           | 46             | \$ 1,888,019           |
| J2350              | INJECTION<br>OCRELIZUMAB 1 MG                           | 25             | \$ 1,059,795           | J9306              | INJECTION<br>PERTUZUMAB 1 MG                            | 202            | \$ 1,633,857           |

# Appendix: BETOS

USED TO IDENTIFY COST TRENDS IN OTHER HEALTH PROFESSIONAL SPENDING

# BETOS

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- Berenson-Eggers Type of Service (BETOS)
- Developed 30 years ago to classify codes in the Medicare Physician Fee Schedule
- Recently updated
- Standardized way to classify professional services
- Modified by us (with Berenson's guidance) to be used with Commercial and Medicaid data
  - Few obstetric encounters in Medicare data
  - Few pediatric encounters in Medicare data

# BETOS

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- NOTE: these specialty classification do not capture episodes of care (that might involve multiple specialties). They capture individual encounters by individuals who have that specialty designation.

# BETOS

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Specialties are aggregated into the following larger groups

1. Primary Care (e.g., FM, Internal Med, Geriatrics)
2. Non-procedural Medical Specialties (e.g., oncology, neurology, psych)
3. Procedural Internal Medicine Specialties (e.g., cardiology, GI)
4. Surgical specialties (e.g., general, Ophtho, Ortho)
5. Other MD specialties (e.g., diagnostic radiology, pathology, ob/gyn)
6. Other Health Professionals (e.g., NP, PA, social workers)



# BETOS

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For each specialty (e.g., diagnostic radiology), spending is broken down into the following groups

1. Anesthesia
2. E&M
3. Imaging
4. Procedures
5. Tests
6. Treatments
7. Unclassified

# BETOS

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## Hierarchy

- 6 aggregated groups (e.g., Surgical Specialties)
  - Individual specialties (e.g., orthopedic surgery within Surgical Specialties)
    - Type of service (e.g., procedures done by orthopedic surgeons)

# BETOS Categories, using 2017 Medicare Data

TABLE C.3

Distribution of Individual Specialty Spending by Broad Service Categories

|  | \$                    | Evaluation and management (%) | Imaging (%) | Major procedures (%) | Other procedures (%) | Treatments (%) | Tests (%)  | Unclassified (%) | Anesthesia (%) |
|--|-----------------------|-------------------------------|-------------|----------------------|----------------------|----------------|------------|------------------|----------------|
| <b>Total 2017 Spending by Broad Service Categories</b> | <b>91,410,976,661</b> | <b>51.3</b>                   | <b>10.9</b> | <b>7.6</b>           | <b>13.5</b>          | <b>9.1</b>     | <b>4.4</b> | <b>0.2</b>       | <b>3.0</b>     |
| Primary Care   | 17,034,243,020        | 91.0                          | 2.5         | 0.3                  | 2.7                  | 2.2            | 1.3        | 0.0              | 0.0            |
| Family Practice  | 6,375,680,839         | 90.2                          | 2.5         | 0.3                  | 3.9                  | 2.1            | 1.0        | 0.0              | 0.0            |
| Internal Medicine                                      | 10,462,252,879        | 91.3                          | 2.6         | 0.3                  | 1.9                  | 2.2            | 1.6        | 0.0              | 0.0            |
| Geriatric Medicine                                     | 196,309,302           | 97.5                          | 0.5         | 0.1                  | 0.9                  | 0.6            | 0.4        | 0.0              | 0.0            |
| <b>Nonprocedural medical specialties</b>               | <b>13,193,486,039</b> | <b>81.8</b>                   | <b>1.9</b>  | <b>0.3</b>           | <b>4.3</b>           | <b>5.6</b>     | <b>6.1</b> | <b>0.0</b>       | <b>0.1</b>     |
| Neurology  | 1,617,863,495         | 64.3                          | 2.9         | 0.7                  | 4.5                  | 1.6            | 26.0       | 0.0              | 0.0            |
| Physical Medicine and Rehabilitation                   | 1,105,270,729         | 67.8                          | 1.8         | 0.4                  | 19.7                 | 3.9            | 6.2        | 0.0              | 0.1            |
| Psychiatry   | 1,164,940,694         | 96.4                          | 0.0         | 0.0                  | 0.1                  | 3.2            | 0.3        | 0.0              | 0.0            |
| Pulmonary Disease                                      | 1,731,860,428         | 82.7                          | 0.6         | 0.1                  | 3.1                  | 0.6            | 12.8       | 0.0              | 0.0            |
| Medical Oncology                                       | 2,003,262,716         | 69.0                          | 5.3         | 0.0                  | 0.6                  | 24.1           | 1.0        | 0.0              | 0.0            |
| Emergency Medicine                                     | 3,176,673,258         | 93.2                          | 0.6         | 0.2                  | 4.1                  | 0.5            | 1.3        | 0.0              | 0.0            |
| Other  | 2,393,614,720         | 87.8                          | 2.1         | 0.3                  | 3.1                  | 5.3            | 1.2        | 0.0              | 0.2            |

1. NOTE: Only part of this Table is shown (the Primary Care and Nonprocedural Medical specialties)
2. This is an example of how BETOS can be used to classify spending into categories that facilitate the identification of cost drivers

# How We Used BETOS

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1. Classified all professional spending using BETOS
2. Looked for year-over-year trends in PMPM spending in the Other Health Professional group
3. When trends were found we looked in detail at the types of utilization, and then at individual CPT codes (to understand whether changes were the result of utilization or price, or both)
4. Note: BETOS can only classify the ~75% of utilization that is attributed to individual providers (it cannot classify utilization attributed to organizations)
5. Commercial and Medicaid MCO LOBs were examined separately

# VBP Subcommittee

# VBP Subcommittee: Steering Committee Member Organization Interest

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1. Amica Mutual Insurance Company
2. Blue Cross Blue Shield of RI
3. Care New England
4. Coastal Medical
5. CVS Health
6. Hospital Association of RI
7. Lifespan
8. Neighborhood Health Plan of RI
9. OHIC
10. RI Parent Information Network (RIPIN)
11. RI Business Group on Health
12. RI EOHHS
13. RI Medical Society
14. RI Public Expenditure Council
15. UnitedHealthcare of New England

# VBP Subcommittee: Outside SME

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- Suggested outside subject matter experts
  - Employers, including municipal/other public group purchasers: RI League of Cities & Towns
  - Organizations representing the interests of consumers: RI Mental Health Association (MHA)
  - Provider groups not represented on the Steering Committee: Prospect Health Services of RI; Thundermist; PCHC
  - Academics or industry experts: Brown University
  - Philanthropic organizations: RI Foundation
  - National expert: TBD
- Propose monthly meetings beginning July 2021
  - During the initial meetings, the VBP Subcommittee will establish a set of operating principles to both guide the process and to govern the transition to advanced VBP

# Low-Value Care



# Low-Value Care

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- At the December 2019 Steering Committee meeting the ABIM Foundation spoke about low-value care and the Choosing Wisely program to reduce it.
- Steering Committee staff subsequently researched evidence that efforts to reduce low value care have produced substantive savings to inform Steering Committee discussion on whether to pursue low-value care reduction as a priority cost growth mitigation strategy
- The project team reviewed published literature, state-level analyses and interviewed individuals involved in low-value care reduction efforts in multiple states, including MO, OR, VA and WA.
- Results were reviewed with the co-chairs in February.

# Low-Value Care

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- The co-chairs recommend that the Steering Committee not initially pursue low-value care as a cost containment strategy for the following reasons:
  - There is limited information on the financial impact of interventions to reduce low value care.
  - States that have implemented strategies targeting low-value care report mixed results (at best) in terms of cost impact.
- Low-value care initiatives should be re-assessed in the future relative to alternative strategies to reduce health care spending growth in order to determine which strategy has the best opportunity for success.
  - If the Steering Committee wishes to pursue low-value care, we recommend beginning with a focused application of low-value care reduction.

# Informational Updates

# Pharmacy Legislation Update

- The letter to the Governor McKee describing this project and expressing support from the Steering Committee for continuation of this work as well as the pharmacy strategy recommendation to introduce, or if already introduced, support the passage of legislation substantially similar to the unsupported prescription drug price increase legislation currently pending in both Connecticut and Massachusetts were transmitted.

# Health Care Spending Transparency and Containment Assessment Status Update

- The State of Rhode Island House of Representatives Committee on Finance heard article 15, section 8 of the state fiscal year 2022 Governor's budget that contains the health care spending transparency and containment assessment on April 15<sup>th</sup>.

# Public Comment

# Next Steps and Wrap-up

# Upcoming Steering Committee Meetings

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- June 28<sup>th</sup> from 9:00-10:30am
- July 26<sup>th</sup> from 9:00-10:30am
- August 23<sup>rd</sup> from 9:00-10:30am
- September 14<sup>th</sup> from 12:00-1:30pm
- October 18<sup>th</sup> from 9:00-10:30am
- November 29<sup>th</sup> from 9:00-10:30am
- December 16<sup>th</sup> from 11:00am-12:30pm