Rhode Island Health Care Cost Trends Steering Committee

FIRST MEETING, AUGUST 29, 2018

Agenda

1.	Welcome and Introductions	9:00 am – 9:15 am
2.	Cost Trends Project Overview	9:15 am – 9:40 am
3.	Cost Trends Project Context	9:40 am – 9:55 am
4.	Data Analysis Goals and Plan	9:55 am – 10:30 am
5.	Break	10:30 am – 10:45 am
6.	Cost Growth Targets – Introduction	10:45 am – 11:40 am
7.	Public Comment	11:40 am – 11:55 am
8.	Next Steps and Wrap-Up	11:55 am - noon

Welcome and Introductions

Steering Committee Members (1 of 2)

Kim Keck | President and CEO | Blue Cross & Blue Shield of Rhode Island **Co-Chair**

Al Kurose, MD | President and CEO |Coastal Medical **Co-Chair**

Tim Babineau, MD |President and CEO| Lifespan

Al Charbonneau | Executive Director | RI Business Group on Health

David Cutler, PhD | Harvard College Professor | Harvard University

Adriana Dawson | VP, Community Development | Bank Newport

James Fanale, MD | CEO | Care New England

Stephen Farrell | CEO | UnitedHealthcare of New England

Marie Ganim, PhD | Commissioner | Office of the Health Insurance Commissioner

Peter Hollman, MD | President-elect | RI Medical Society

Steering Committee Members (2 of 2)

Christopher Koller | President | Milbank Memorial Fund

Betty Rambur, PhD, RN, FAAN | Professor of Nursing | URI College of Nursing

Samuel Salaganik, Esq. | Attorney & Health Policy Analyst |RI Parent Information Network

John Simmons | Executive Director | RI Public Expenditure Council

Neil Steinberg | President & CEO | Rhode Island Foundation

Teresa Paiva Weed, Esq. | President | Hospital Association of Rhode Island

Lawrence Wilson| Managing Director| The Wilson Organization, LLC

Staff Supporting the Health Care Cost Trends Project

State of Rhode Island

Cory King | Principal Policy Associate |OHIC

Kim Paull | Director Data Analytics |EOHHS

Jaclyn Porfilio | Policy Advisory| Governor's Office

Bailit Health

Michael Bailit | President

Megan Burns | Senior Consultant

Erin Taylor |Senior Consultant

Justine Zayhowski | Consultant

Brown University

Ira Wilson | Professor and Chair of the Department of Health Services, Policy and Practice

Anya Rader Wallack | Associate Director, Center for Evidence Synthesis in Health

Megan Cole | Assistant Professor |Department of Health Law, Policy and Management |Boston University School of Public Health

Project Support

The Peterson Center on Healthcare is providing support for this project through June 30, 2019.

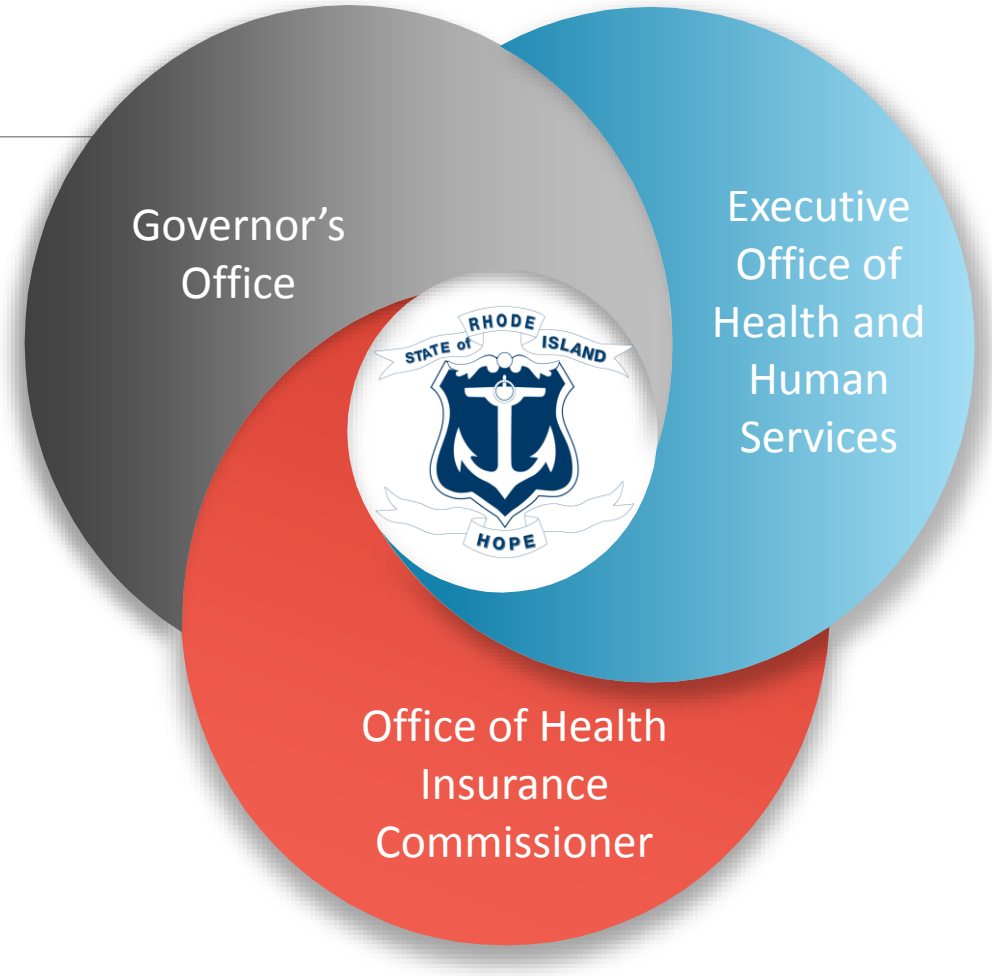
The Peterson Center on Healthcare was established by the Peter G. Peterson Foundation to transform US healthcare into a high-performance system by finding innovative solutions that improve quality and lower costs and accelerating their adoption on a national scale.

Cost Trends Project Overview

Vision Statement

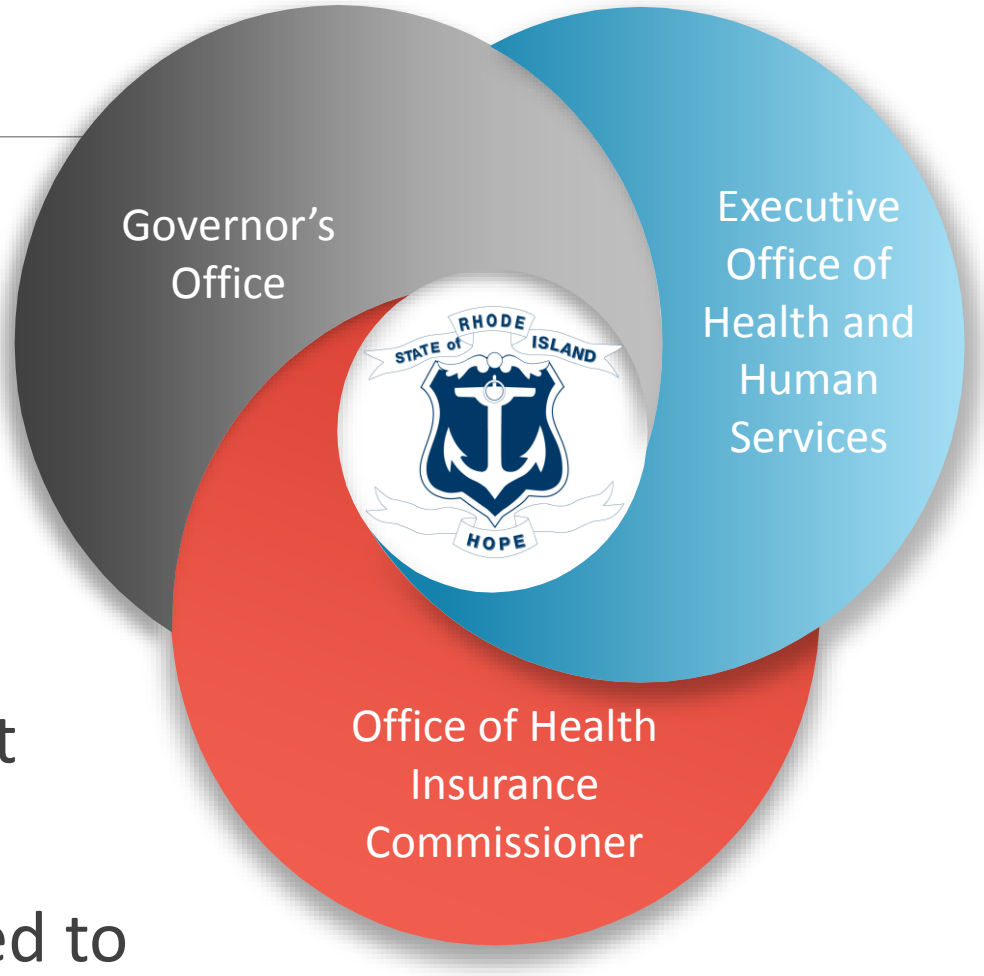
To provide Rhode Island citizens with high-quality, affordable health care through greater transparency of health care performance and increased accountability by key stakeholders

– Peterson Grant Application



Project Goals

1. Reduce growth in health care costs by:
   - developing a cost growth target, and
   - providing transparent health care performance data to influence purchasing decisions and care delivery reforms.
2. Develop a deeper understanding of cost drivers and cost variation in Rhode Island.
3. Determine what investments are needed to sustain ongoing analysis.

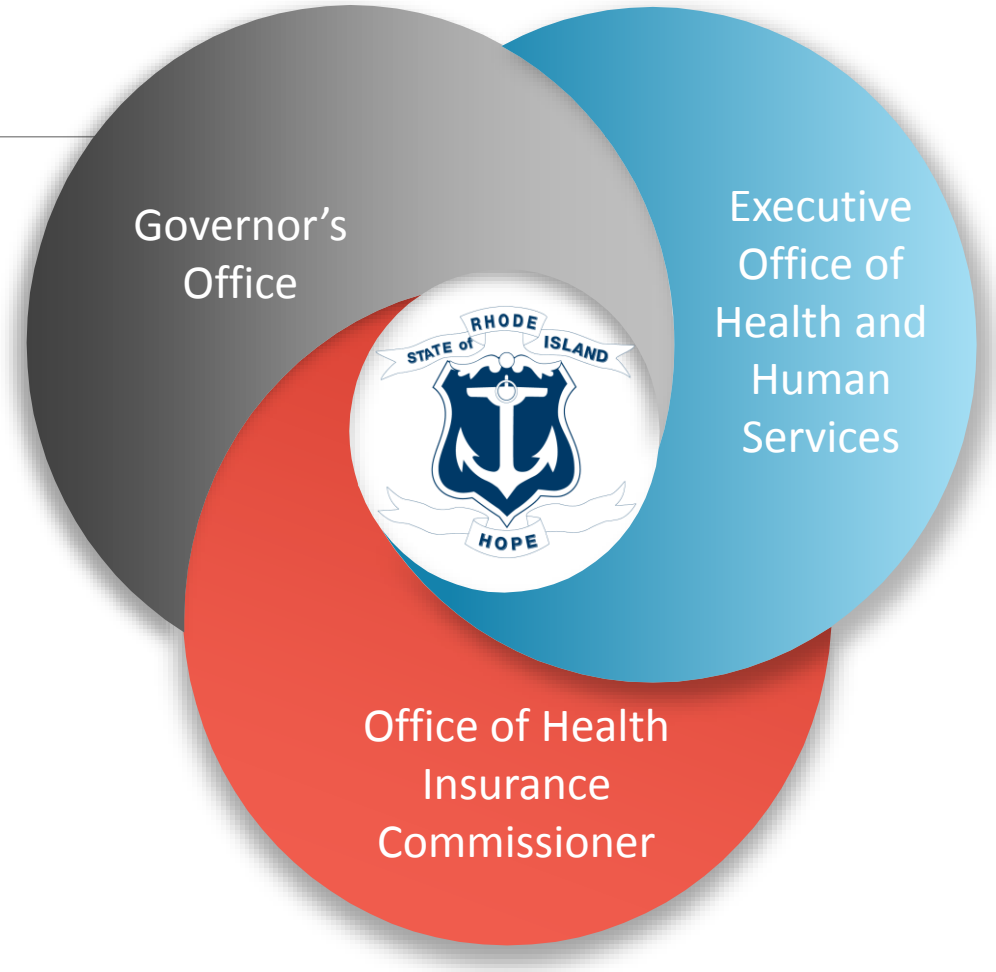


Cost Trends Project Work Streams

The methodology for a health care cost growth target will be developed for operationalization in 2019

Brown University will conduct a data analysis to measure health care system cost performance

A data use strategy will be developed to leverage the RI APCD in identifying cost drivers and sources of cost growth variation to improve health care system performance



Steering Committee Charge

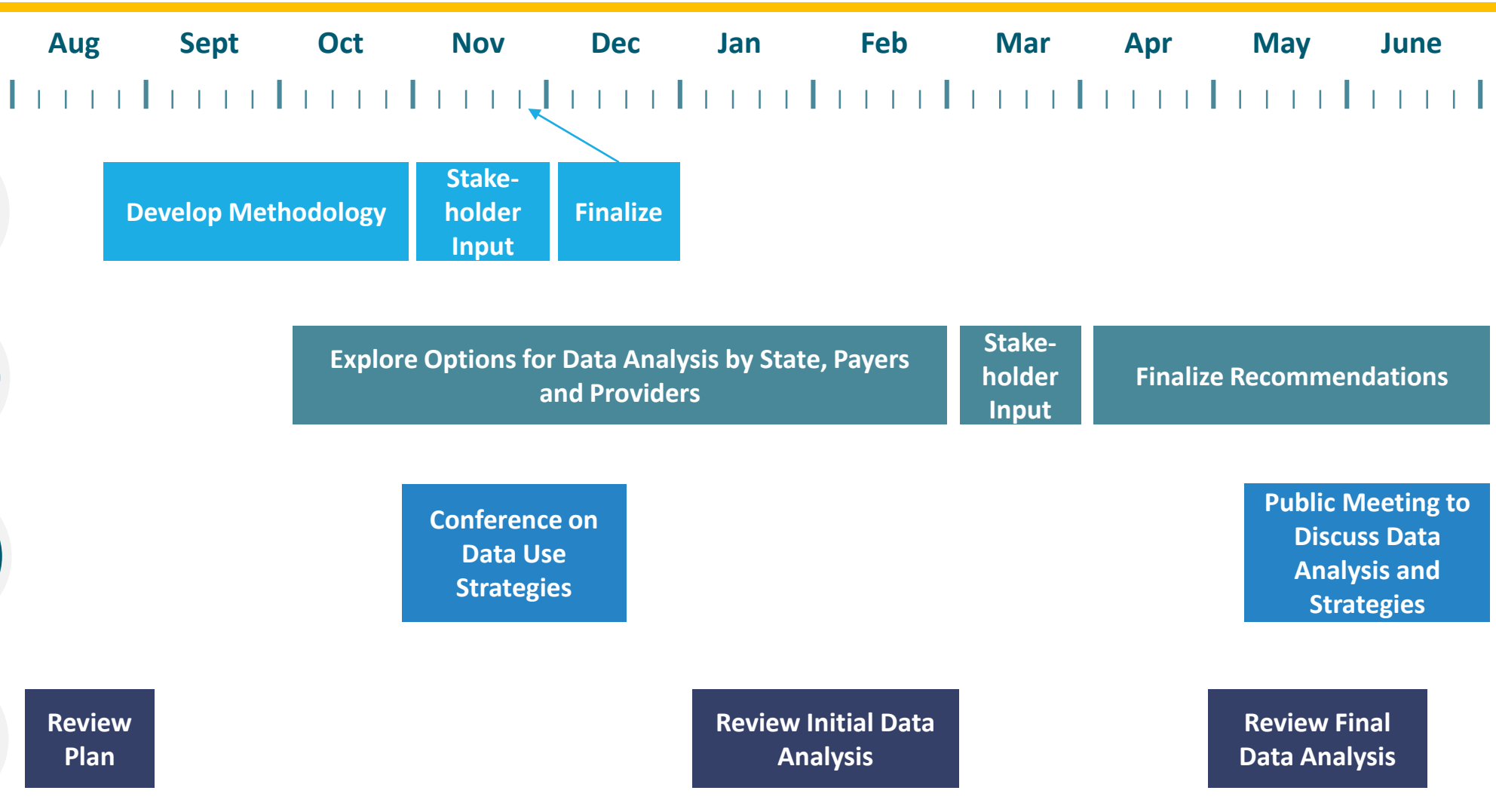
The Steering Committee will specifically advise the State on:

1. the methodology to **measure** and **report** on the **total cost of health care** in Rhode Island;
2. the methodology to establish an **annual health care cost growth target** to first employ in 2019;
3. how to **analyze and report publicly** on state, insurer and provider performance relative to the target;
4. a data analysis plan designed to **measure health system cost performance** on a pilot basis during 2018-19, and
5. a data analysis and use plan to guide **future, ongoing analysis** of cost growth drivers and sources of cost growth variation.

Steering Committee Charge, cont'd

- By agreeing to serve on the Steering Committee, you are committing to participate in a thoughtful and respectful process to consider the Steering Committee's charge and make recommendations to the State.
- The scope of work is considerable and will be fast-paced. In order to facilitate progress, staff will prepare content to which you can respond. Please come to each meeting prepared, to the extent material was shared with you in advance.

Cost Trends Project Timeline



Cost Trends Work: Context

2016 Planning

- During 2016 a large public stakeholder group wrestled with how to pursue a cost trend target for Rhode Island as a means to contribute to slowed cost growth
- Later in the year, Governor Raimondo invited a small group of stakeholders to provide her with advice on how best to fashion a cost growth target for Rhode Island. Some of the members of this steering committee participated in that effort.
- The work resulted in December 2016 recommendations to the Governor.
- The recommendations included the following:
  - *The State should only pursue a cost growth target strategy...if it takes parallel action to...rigorously analyze drivers of cost and cost growth...*
- Further work was delayed until the Peterson Foundation agreed to fund the analysis of cost and cost growth drivers, and development of a plan for sustaining this work into the future. We are now beginning the work anew!

2016 Planning and Today

- Several Steering Committee members participated in the 2016 process.
- The new process is different than that of two years earlier in three important ways:
  - The Peterson Foundation, through its Center on Healthcare, is providing financial support for robust data analysis to understand cost drivers and to develop a plan for sustained data analysis activity into the future.
  - The small planning group of 2016 has been expanded to include a diverse set of interests and perspectives.
  - More is known about the experience of Massachusetts, and Delaware has since undertaken its own cost growth target and data analysis strategy.

Data Analysis Goals and Plan

OVERVIEW OF BROWN'S PROPOSED ANALYSIS

Agenda

- Long-term goals
- Short-term goals
- Analytic methodology:
  - Study population
  - Patient attribution
  - Data sources
  - Outcome definitions
  - Analytic approach, Aim #1: cost trends
  - Analytic approach, Aim #2: cost drivers
  - Analytic approach, Aim #3: deconstructing cost by price and volume

Proposed approach

Long-term goals

To determine:

- What type of data analysis on health care performance needed to inform purchasing decisions and care delivery reforms
- What investments are needed to ensure sustainability of analysis

Short-term goals

To analyze RI all-payer claims database (APCD) to identify cost trends and select drivers of cost:

- Aim #1: To assess cost trends in RI
- Aim #2: To assess select cost drivers in RI
- Aim #3: To further deconstruct cost by volume and price

Study Population

Inclusion criteria
Rhode Island residents
All payers: commercial, Medicaid (MCOs, FFS), Medicare (FFS, MA)
All major health plans: Blue Cross and Blue Shield, Neighborhood Health Plan, UnitedHealthcare, Tufts Health Plan, Medicaid fee-for-service, and Medicare fee-for-service
Exclusion criteria
Rhode Island residents who receive the majority of their primary care outside of RI*
Non-RI residents receiving care in RI
Enrollees with <12 months of continuous coverage during the study period (2014-2017)
Health plans comprising a small minority of covered lives in Rhode Island (e.g., Cigna, Harvard Pilgrim, Aetna)
Covered lives not reported in APCD: e.g., some self-insured; VA; TRICARE; uninsured

Data sources

- RI All-Payer Claims Data (APCD) (2014-2017*)
- For patient attribution to PCPs: APCD (utilization-based)
- For PCP attribution to provider groups: provider directories from RIQI and RI ACOs and medical groups
  - Availability may vary
  - No single ideal source

Patient Attribution

- Attributed on monthly basis:
  - Health plan and payer attribution: based on enrollment start and end dates using monthly member files in APCD
  - Provider attribution: health plan PCP designation OR utilization-based PCP assignment (plurality of primary care visits in last 24 months) → attributed to provider group based on PCP

Defining total cost of care

- Measured as total expenditures per person per month, with monthly member expenditures aggregated across each calendar year, weighted by member months.
- Calculation from APCD:

$$Y_{it} = \sum ([\text{Total Medical Expenditures} + \text{out of pocket spending}] / \text{Medical Member Months}) + ([\text{Total Pharmacy Expenditures} + \text{out of pocket spending}] / \text{Pharmacy Member Months})$$

- Expenditures to be inflated by price adjustment factor based on 2018 dollars and truncated at $125,000 per member, per HealthPartner's Total Cost of Care methodology

What claims-based costs cannot measure: administrative costs, lump sum or other non-claims-based payments to providers

Adjustment for Patient Characteristics and Health Status

Expenditures per person will be risk adjusted for the following:

- Age
- Sex
- Health status → 3M Clinical Risk Groups (CRGs)
- Presence of select chronic conditions (asthma, chronic obstructive pulmonary disorder, congestive heart failure, depression, diabetes, hypertension, ischemic heart disease)
- Indicator for pregnancy or childbirth
- Zip code index (based on median income in zip code)
- Area deprivation index
- *Race/ethnicity, depending on data availability*

3M CRG:

- Claims-based
- All payers & ages
- 1080 different clinical groups and 9 major clinical CRG statuses (using patient diagnoses)
- Used by VT with its APCD

Aim 1 Analytic Approach: Cost Trends

- Calculated as mean annual risk-adjusted medical expenditures per person per year
- For each year, we will report:
  - Mean annual medical expenditures per person
  - Median expenditures per person
  - Expenditures by quintile
  - Total member enrollment
- Will also report year-to-year statistical trends

Stratified by payer (e.g., commercial, Medicaid MC, Medicaid FFS, Medicare Advantage, Medicaid FFS, dual eligible)

Aim 2 Analytic Approach: Cost Drivers

- All decomposition analyses to be stratified by payer type, health plan, and provider group. Prioritize 2-4 measures.

Annual expenditures by category of medical spending

- Inpatient hospital, medical/surgical, and maternity;
- Inpatient post-acute, rehab., and nursing facility;
- Outpatient care;
- Outpatient care behavioral health
- Primary care;
- Primary care behavioral health;
- All other physician and professional services
- Long-term services and supports;
- Pharmacy; and
- Other medical

Annual expenditures by sub-group

- Health risk score
- Age group
- Gender
- County

Aim 3 analytic approach: volume & price

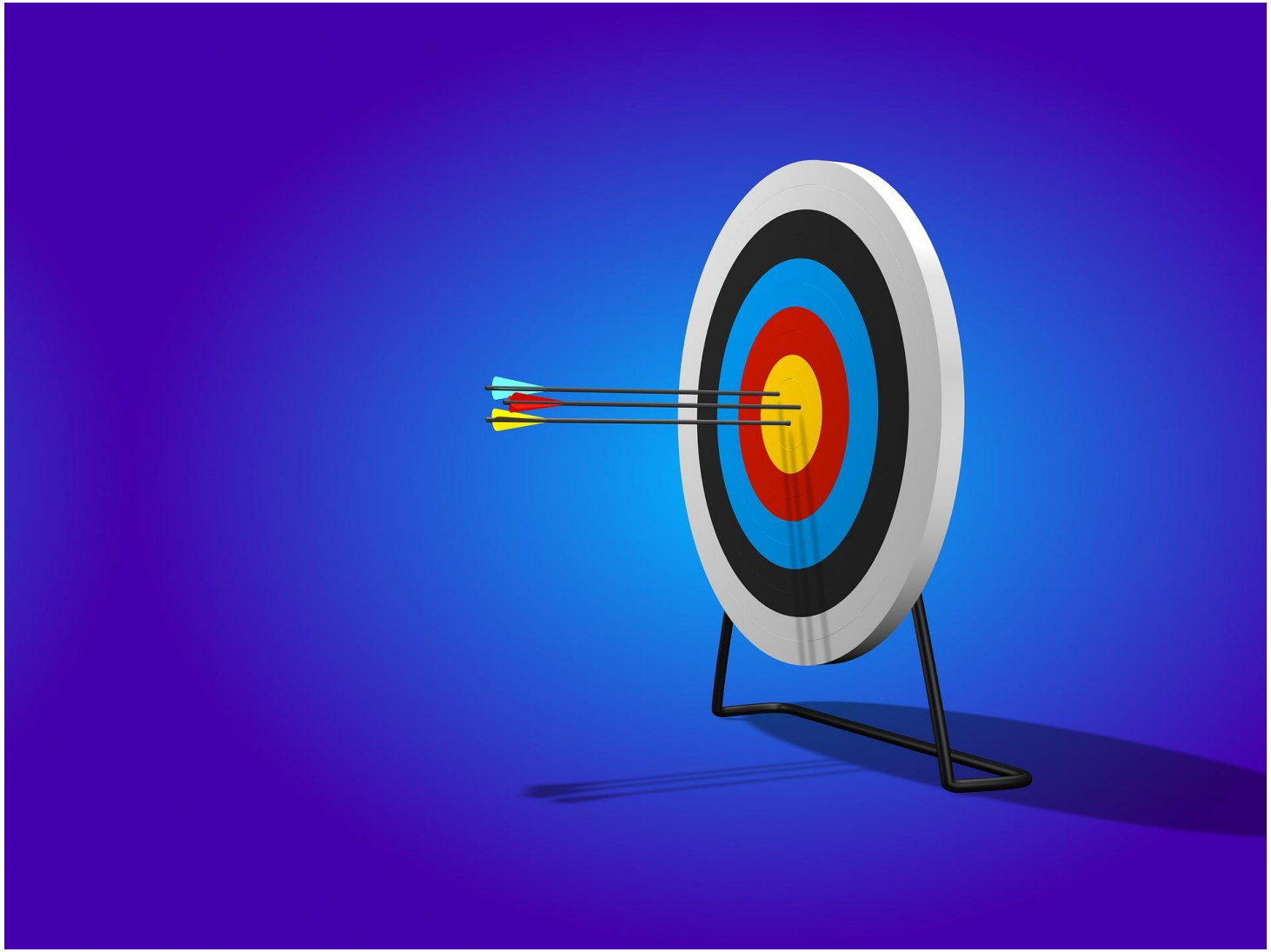
Price & Volume (utilization-based)	
Volume	**Number per 1000 patients**: Inpatient days, nursing facility days, ED visits, outpatient visits, other professional or primary care visits
"Price and intensity"	**Price per day or visit**: inpatient days, nursing facility days, ED visits, outpatient visits, other professional or primary care visits
Price & Volume (episodes of care)	
Volume	**Number of episodes per 1000 patients**: ▪ Select Altarum episodes ▪ Other states have examined: knee replacement, pulmonary embolism, spinal fusion, simple pneumonia, heart stent, heart arrhythmia, knee MRI, colonoscopy, upper GI endoscopy, evaluation & management visits, MRI scan of brain, echo-cardiogram
Price	**Price per episode**: Same as above

Can assess **utilization-based** volume and price separately for each year by payer, health plan, and provider group.
Altarum episodes to be stratified by provider type (hospital v clinician) and payer (Medicaid v commercial), 7/16-6/17 only

Data Analysis Goals and Plan: Questions and Discussion

Cost Growth Targets

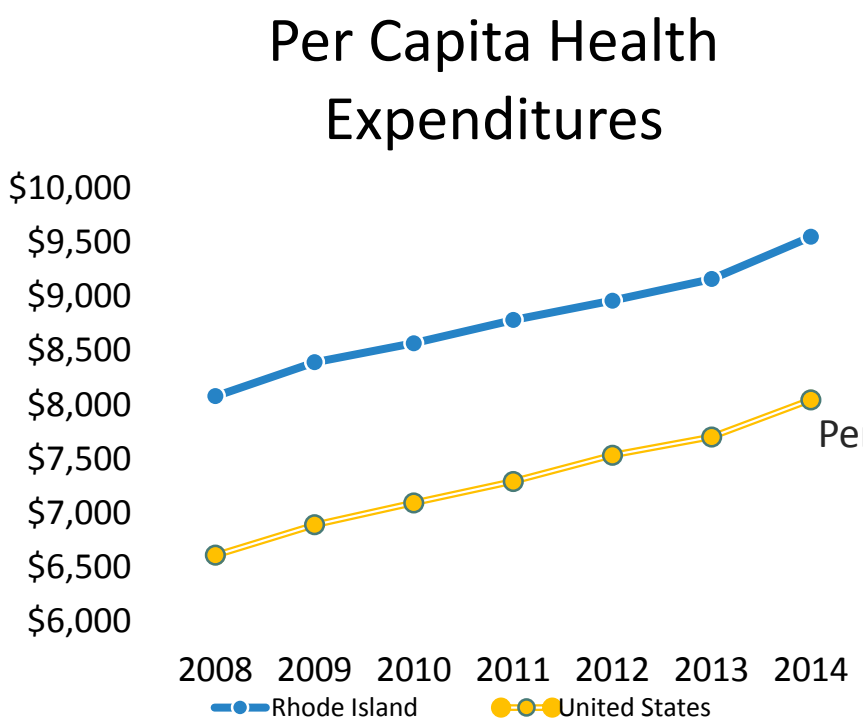
INTRODUCTION, GROUP PROCESS AND MEASURING SPENDING



What is a health care cost growth target?

A health care cost growth target is a per annum rate-of-growth target for health care costs in Rhode Island.

Why would Rhode Island want to pursue a cost growth target?



10th Highest

Per Capita Expenditures Among All States

6% - 8.1%

2018 Growth in Small Group Market Commercial Rates

8% - 10.5%

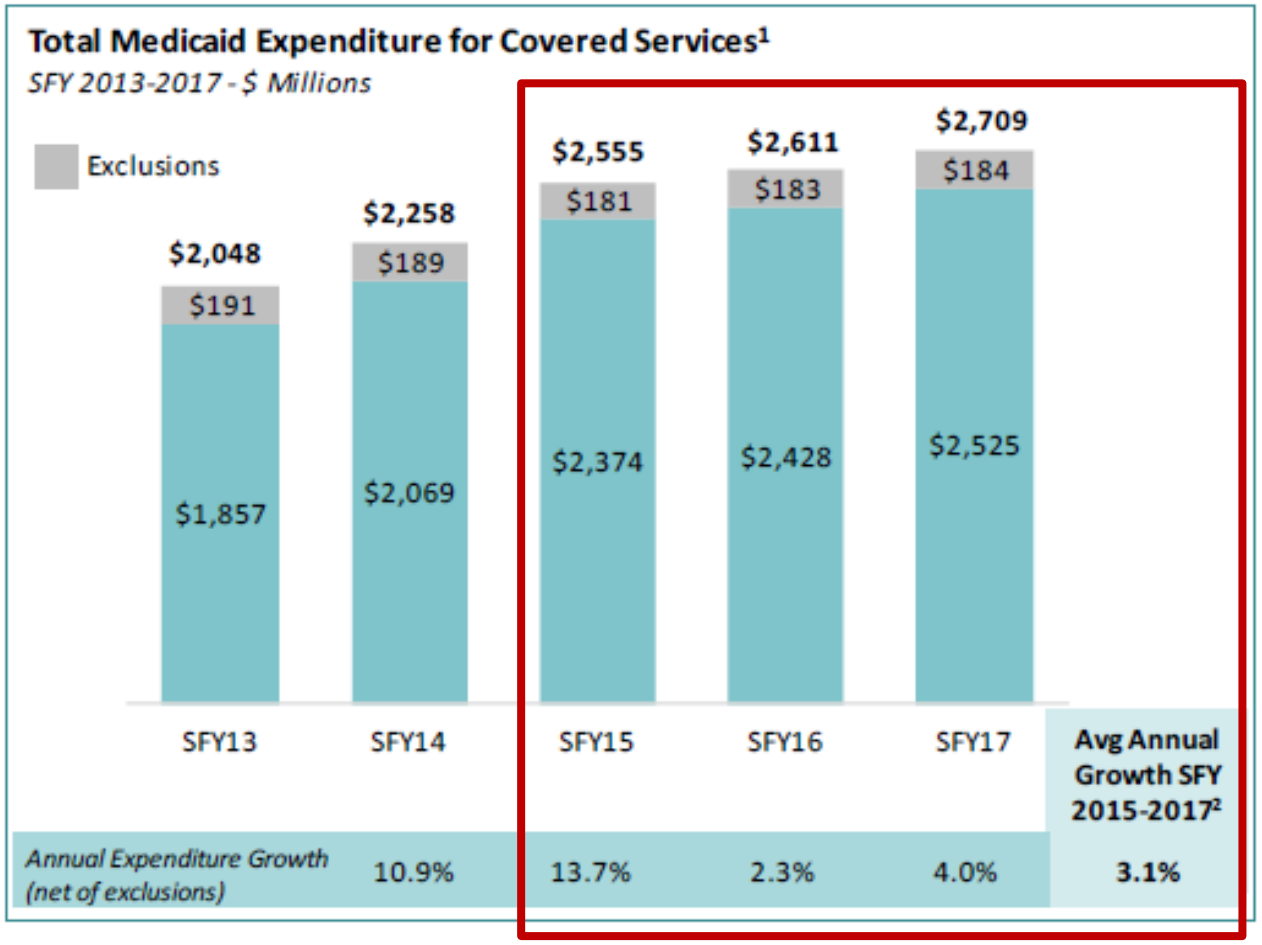
2018 Growth in Large Group Market Commercial Rates

3.7%

Q1 2018 Annual Wage Growth

Sources: Kaiser Family Foundation, OHIC, Bureau of Economic Analysis

RI Medicaid Expenditure Trends



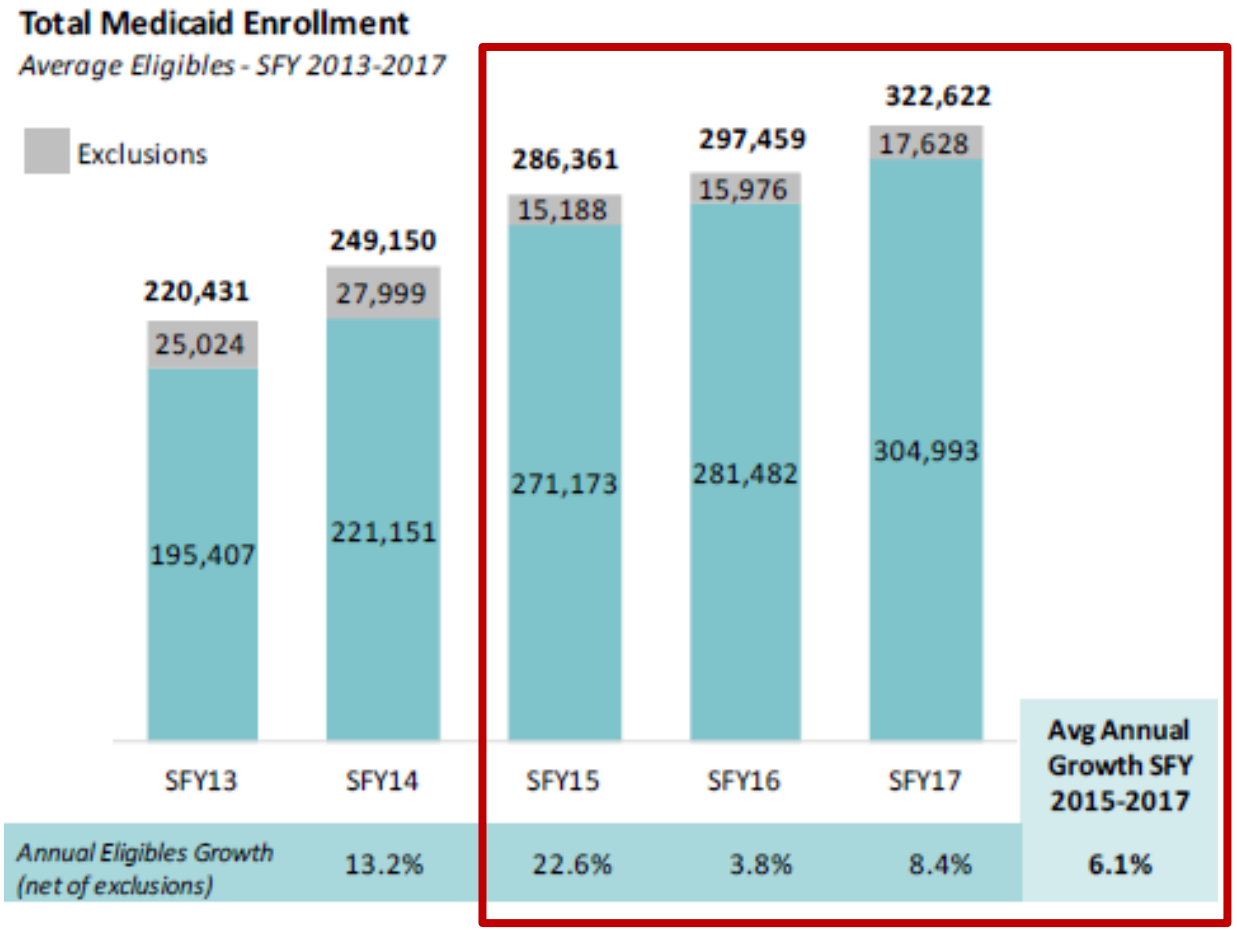
- Medicaid expenditures **increased 3.1%** per year on average from 2015 to 2017.
- Trends focus on the past three years since implementation of the ACA stabilized in 2015.

Notes:

- [1] Annual expenditure includes the spending for both fully covered and partially covered enrollees
- [2] Calculated as compounded annual growth rate (CAGR) over period SFY 2015-2017.
- Excluded populations: members who are eligible for partial benefits (e.g.: individuals who receive assistance only with their Medicare premium payments and populations receiving services under a CNOM program).

Source: RI Annual Medicaid Expenditure Report SFY 2017, EOHHS

RI Medicaid Enrollment Trends



- Medicaid enrollment of the fully covered populations has **increased 6.1%** per year on average from 2015 to 2017.
  - Includes expansion population
  - ACA implementation on 1/1/2014 resulted in increased enrollment for both expansion and non-expansion populations.

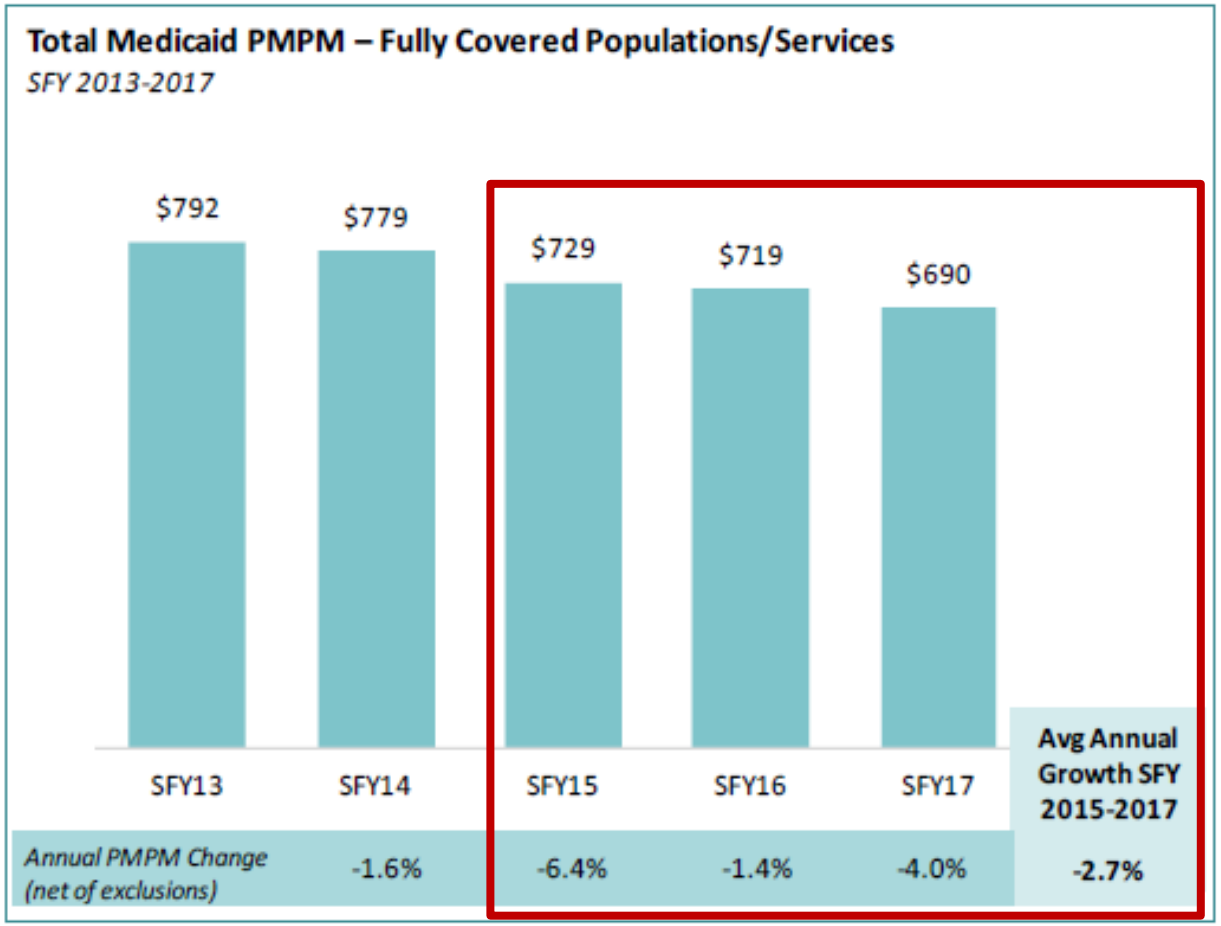
Note re: excluded populations: members who are eligible for partial benefits (e.g.: individuals who receive assistance only with their Medicare premium payments and populations receiving services under a CNOM program).

Source: RI Annual Medicaid Expenditure Report SFY 2017, EOHHS

RI Medicaid Expenditure PMPM Trends

Total Medicaid PMPM – Fully Covered Populations/Services

SFY 2013-2017



- Medicaid PMPM has **decreased 2.7%** per year on average from 2015 to 2017
- Growth since 2014 primarily from populations with relatively low costs (e.g., children and low-cost adults)
- Report also attributes decrease, in part, to the State's Reinventing Medicaid Initiatives, including
  - cuts to hospital and nursing home reimbursement rates, and
  - savings for new care coordination initiatives between health plans and providers.

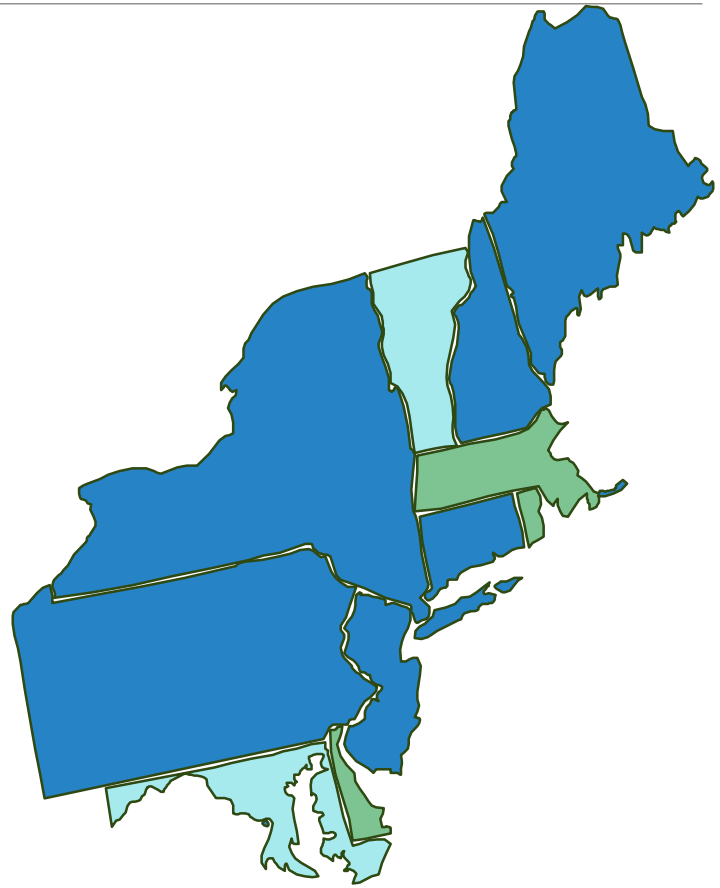
Note re: excluded populations: members who are eligible for partial benefits (e.g.: individuals who receive assistance only with their Medicare premium payments and populations receiving services under a CNOM program).

Source: RI Annual Medicaid Expenditure Report SFY 2017, EOHHS

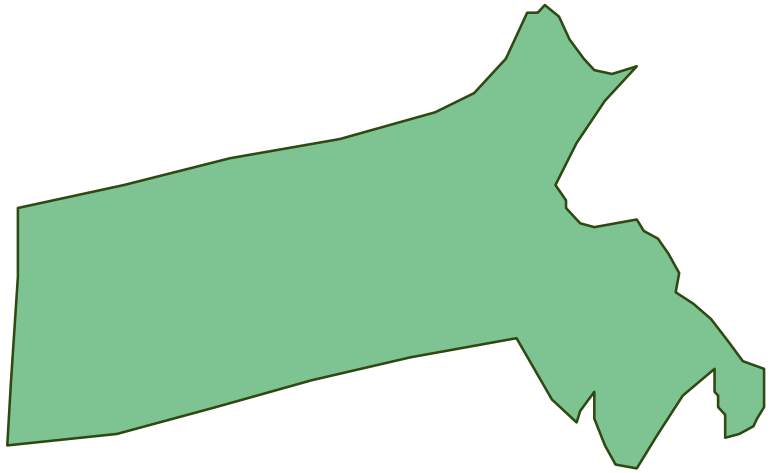
Experience from Other States

While Rhode Island's cost growth target needs to be designed by and for Rhode Islanders, it is informative to understand how other states have established and applied cost growth targets.

- Massachusetts is the only state that has operationalized a true health care cost growth target.
- Delaware is establishing one to start in 2019.
- Maryland and Vermont have experience with related activity.



Massachusetts Health Care Cost Growth Target



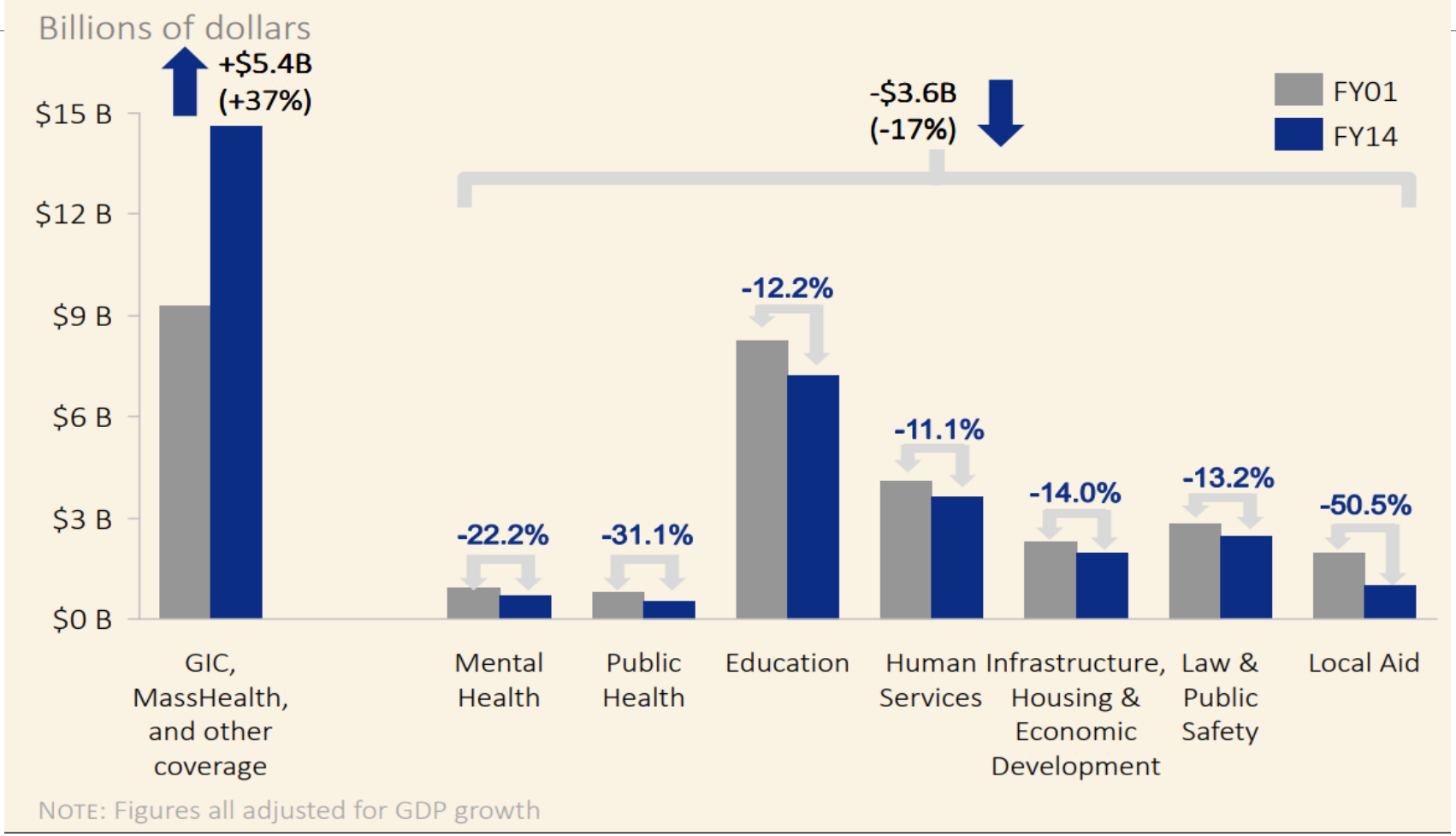
Mass. Chapter 224 of the Acts of 2012 created the Health Policy Commission (HPC):

- a quasi-independent entity that resides within, but not under the control of, the Executive Office for Administration and Finance
- charged with establishing **an annual cost growth target** and monitoring progress through annual public cost trends hearings

What was the purpose? To inform the public and to drive behavior change within the delivery system.

- "To give certainty about how much medical care costs and to lower it from what it otherwise would have been." – Health Policy Commission member

The impact of health care spending on the Massachusetts state budget, SFY01-SFY14



Source: Health Policy Commission, 2013 Cost Trends Report, data from the Massachusetts Budget and Policy Center

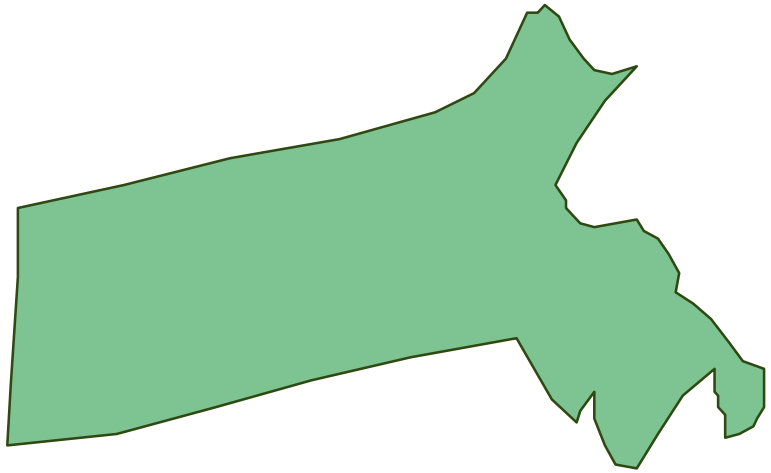
Massachusetts Health Care Cost Growth Target

By April 15th of each year, the HPC must set the target growth rate for **average total per person** medical spending in the state for the next calendar year.

The health care cost growth benchmark is tied to expected long-term growth in the state's economy—specifically the **potential gross state product** (PGSP).

The Secretary of Administration and Finance and the House and Senate Ways and Means Committees must agree on the target by January 15th.

Massachusetts Health Care Cost Growth Target



Beginning in 2018, the target changed to PGSP -0.5%. The HPC has some discretion to modify the target (up to PGSP). In 2022, the default target value is set at PGSP and the HPC is able to set the target without restriction.

The target is primarily intended for state-level use, but…

…providers and payers are also assessed. Who? By statute...

- clinics, hospitals, physician organizations, accountable care organizations and payers
- excluding, physician contracting units with a panel of 15,000 or fewer, or which represent providers who collectively receive less than $25M in annual net patient service revenue from carriers

Massachusetts Health Care Cost Growth Target

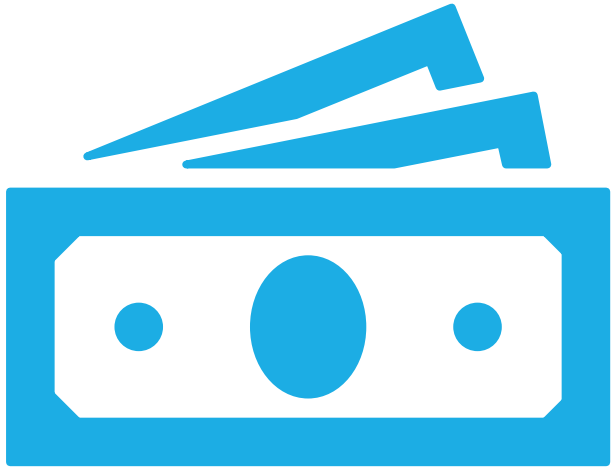
What happens if an organization exceeds the target?

- The HPC *may* require health care entities that exceed the benchmark to file and implement performance improvement plans.
- An entity can be fined up to $500,000 for failure to submit, implement, or report on its performance improvement plan.

What happens if the benchmark strategy doesn't work?

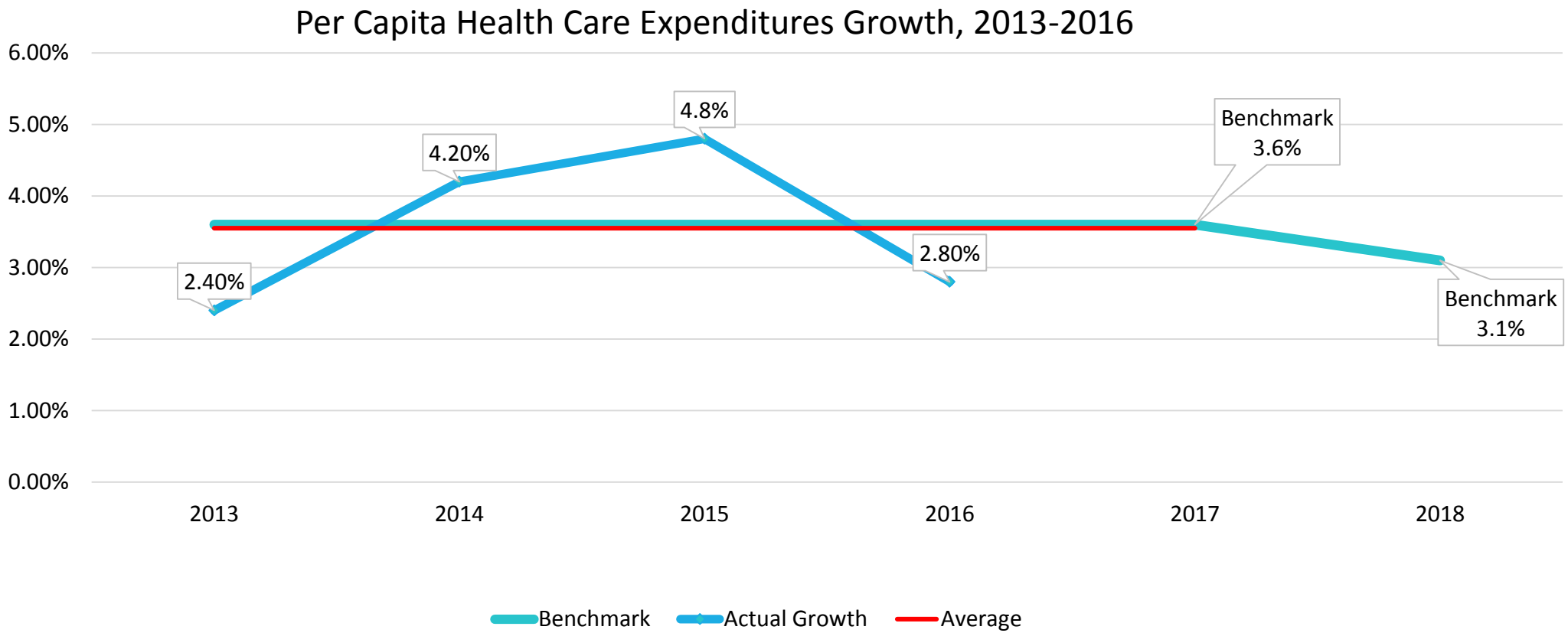
- "The commission may submit a recommendation for proposed legislation to the joint committee on health care financing if the commission determines that further legislative authority is needed to achieve the health care quality and spending sustainability objectives of this act, assist health care entities with the implementation of performance improvement plans or otherwise ensure compliance with the provisions of this section."

What exactly is Massachusetts measuring?



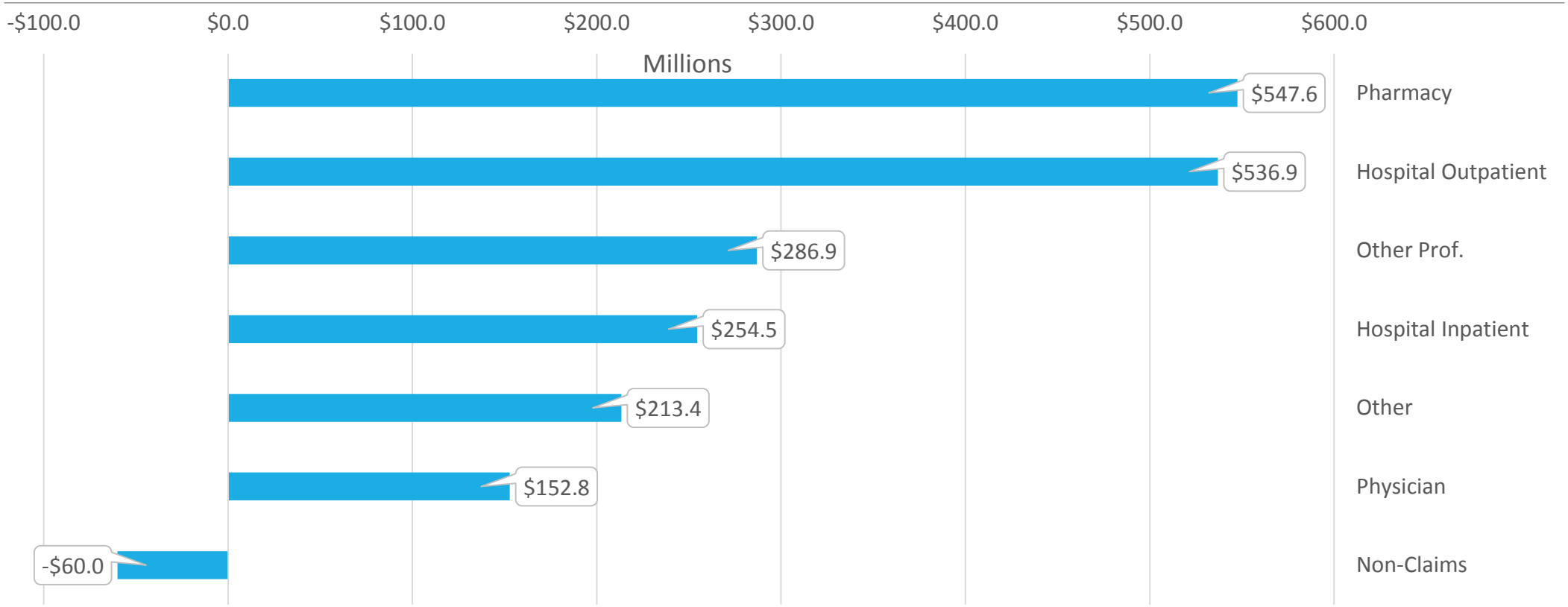
- Total health care expenditures (THCE) is a per-capita measure of total state health care spending growth. It has three components:
  1. all medical expenses paid to providers by private and public payers, including Medicare and Medicaid
  2. all patient cost-sharing amounts (e.g., deductibles and co-payments)
  3. the net cost of private health insurance (e.g., administrative expenses and operating margins for commercial payers)

Massachusetts Experience to Date



Sources: Center for Health Information and Analysis (CHIA) Performance of the Massachusetts Health Care System Annual Report, September 2017; Total Health Care Expenditures from payer-reported data to CHIA and other public sources.

Massachusetts Experience: Largest Drivers in Health Care Cost Growth



Change in Health Care Expenditures by Service Category, 2015-2016

Sources: Center for Health Information and Analysis (CHIA) Performance of the Massachusetts Health Care System Annual Report, September 2017; Payer-reported TME (excludes admin & margin) data to CHIA and other public sources.

Massachusetts Experience To Date

"Payer and provider rate negotiations are now conducted in light of the 3.6% target." (State Auditor study)

"With an expected utilization increase of about 2%, payers and providers generally agree on annual price increases of about 1.5%." (David Cutler)

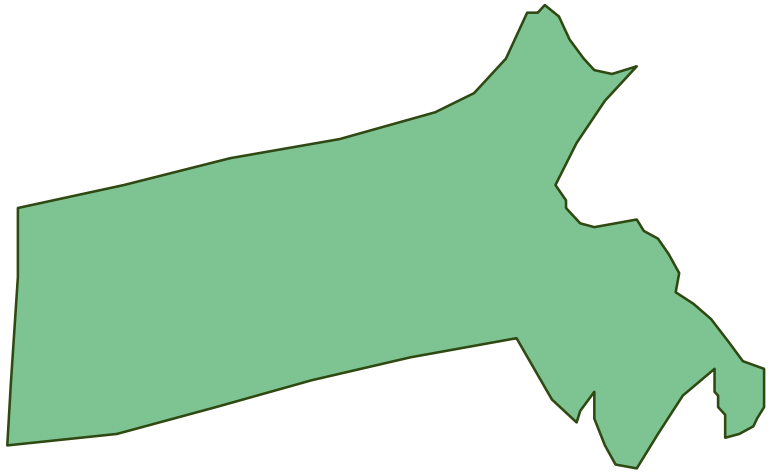
"My sense is that the people who provide care have been very conscientious about trying to lower spending…The law is having an effect." (Stuart Altman, HPC Chair)

"The [cost growth benchmark] does mean something. It sets the bar upon which most activities in the health system are judged. It's more than just a symbol, it's become an operational component of how our health system works." (Stuart Altman, HPC Chair)

Concerns Raised in Massachusetts

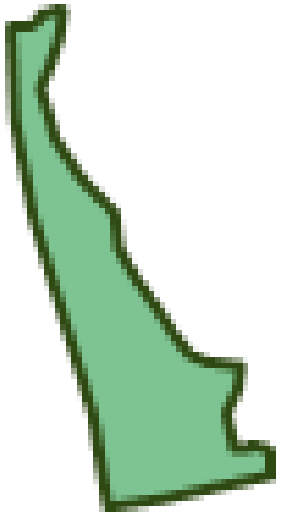
1. GSP is a poor basis for setting a target.
   - There is no correlation between medical spending and state gross domestic product, so why make the linkage? (Archambault *Health Affairs* blog (2013))
   - GSP is a poor proxy for "affordability." (Fuller, RAND)
2. It is unfair to include federal spending over which state actors have no policy influence. (Fuller, RAND)
3. Growth caps lock in historical disparities and inequities in payment.
4. Some health care costs – notably new breakthrough technology costs – but also epidemics and other unforeseen occurrences are beyond the control of providers and insurers.

Massachusetts Health Care Cost Growth Target



We will spend more time looking closely at the details of the Massachusetts design and experience as we begin to delve into our cost growth target work in coming meetings.

Delaware Health Care Cost Growth Targets

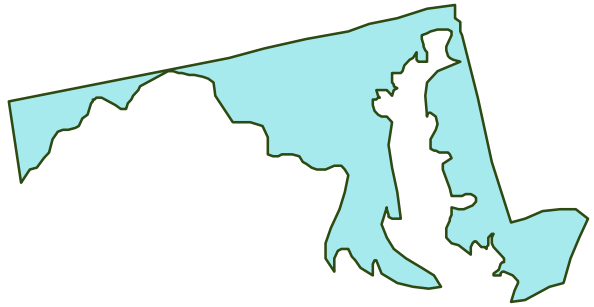


Delaware is in the process of establishing health care cost growth targets. It is pairing the cost growth target with quality targets.

- An Advisory Group established to support the establishment of the cost growth target recommended utilizing the same measure of economic growth (potential gross state product) as did Massachusetts.
- The Advisory Group recommended measuring cost growth in a similar manner as Massachusetts, but without any form of penalty for any plan or provider that is above the target.
- We will share more detail on Delaware in future meetings as the state's plans become public in the next few weeks.

Maryland

- Maryland has been regulating hospital rates under a federal waiver since the 1970s.
- Until recently, however, Maryland did nothing to regulate service volume. As a result, volume grew significantly.
- In 2014, Maryland moved to a **hospital global budget model** where hospitals could only accrue a budgeted amount of revenue from all payers, with the goal of limiting hospital volume and shifting care to less costly settings.
- Hospital global budgets became effective July 1, 2014.



Maryland Hospital Global Budget Methodology

- A global budget is set for each hospital using baseline data from 2013 on its revenue and volume.
- Each year the budget can be adjusted for:
  - Inflation: estimated growth minus expected productivity gains from growth in hospital costs
  - Volume adjustment: (1) adjustments based on population demographics; (2) adjustments for changes in market share (only when there are offsetting volume changes at other hospitals in the market); and (3) adjusted from reductions in potentially avoidable utilization
  - Quality: improved quality can increase the global budget
  - Uncompensated care: historical and projected spending for charity care and bad debt

Maryland
Health Care Cost Growth Target

As part of Maryland's waiver agreement with CMS, the State limited all payer per capita inpatient and outpatient hospital growth to the long-term projected per capita state economic growth (GSP) – **3.58%.**

Medicare also required savings for its Maryland beneficiaries to be a minimum of $330 million over 5 years.

The agreement also included patient / population centered-measures and targets:

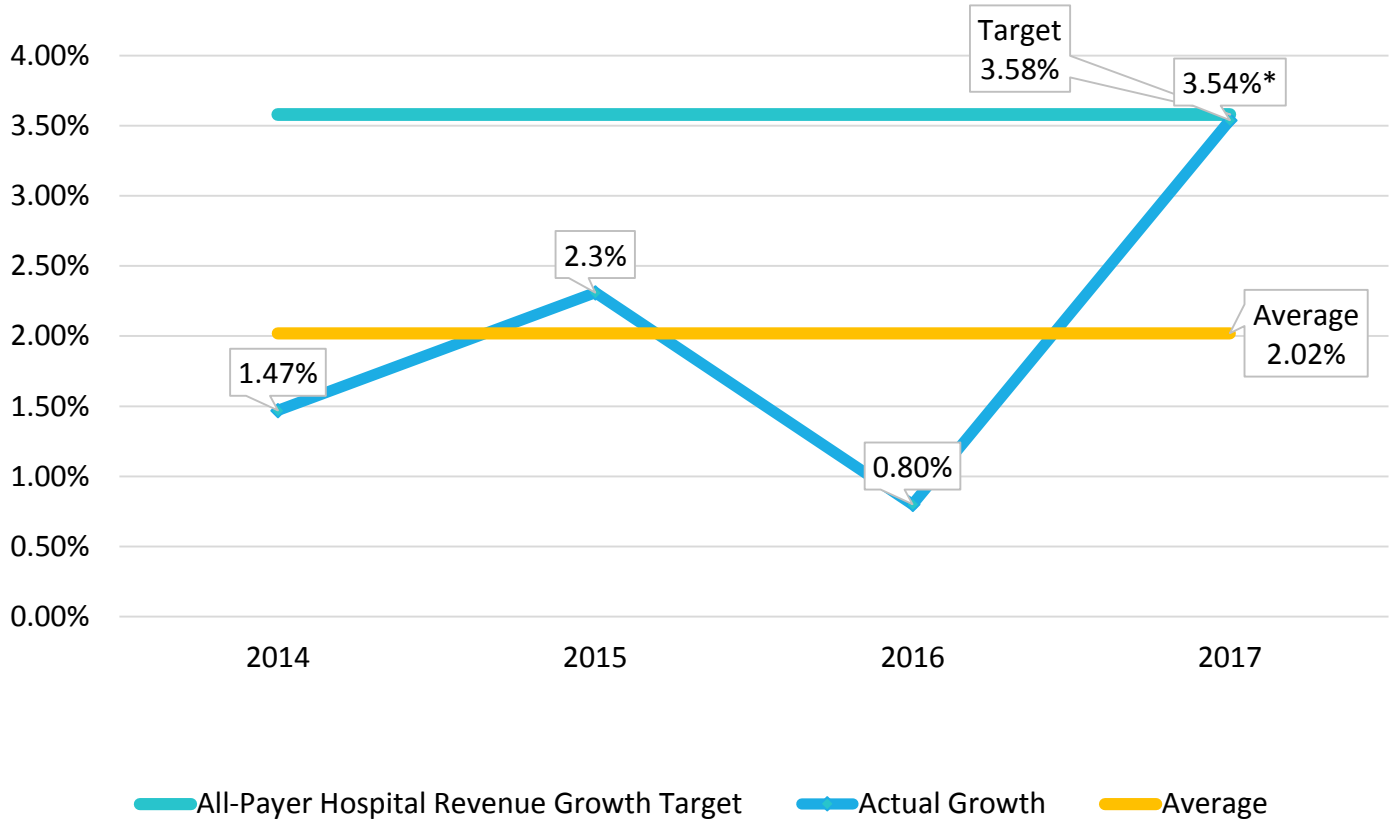
- Medicare readmission reductions to national average
- 30% reduction in preventable conditions over a 5-year period
- Quality-related revenue at risk to equal or exceed Medicare programs

Maryland
Health Care Cost Growth Target

There are big consequences if Maryland doesn't meet its goals. If it fails during the five-year performance period, Maryland will have to transition back to the national Medicare payment system.

So how has Maryland done….?

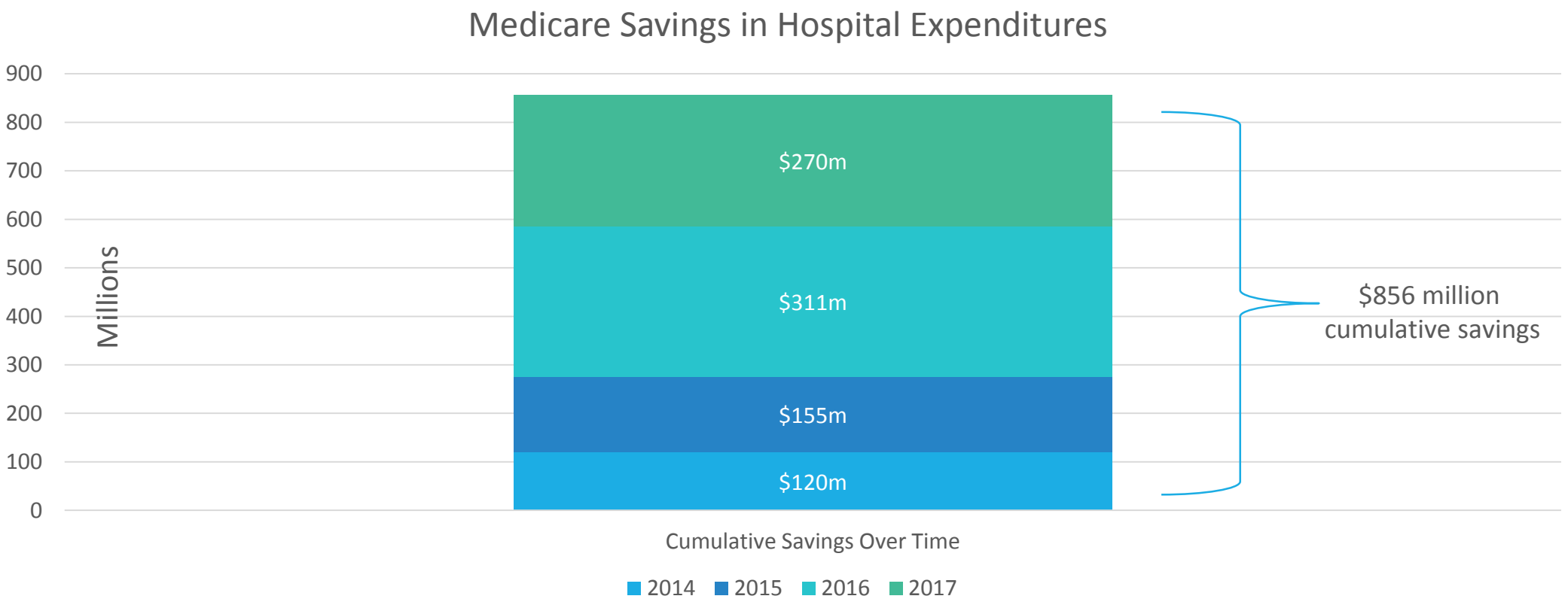
Maryland Results



Source: Health Services Cost Review Commission: All-Payer Model Results, CY 2014-2017

- While the raw financial results are positive, evaluations have shown:
  - Medicare admission reductions have been achieved, but not so for privately insured patients (Haber et al., RTI International)
  - No evidence of reduction in utilization relative to a control group (Roberts et al., *JAMA*)
  - No changes in hospital use or price-standardized hospital spending (Roberts et al., *Health Affairs*)

Maryland Results

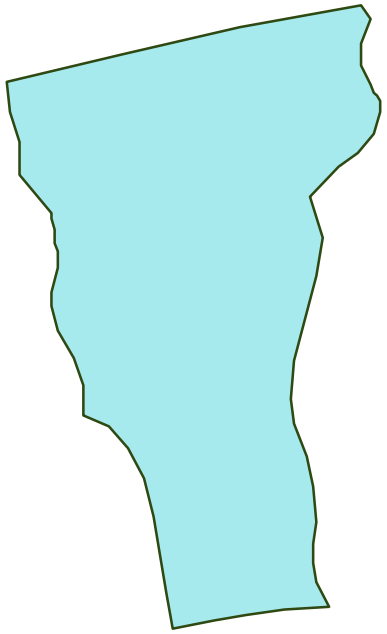


*2017 results are preliminary and not validated by CMS, 2017 figures are only through October 2017

Source: Health Services Cost Review Commission: Budget Analysis, February 22, 2018

Vermont

In 2017 Vermont entered into an all-payer ACO model with Medicare, Medicaid (under an 1115 waiver), commercial payers and the state's sole ACO. The model anticipates providing care to 70 percent of all Vermont residents and 90 percent of all Vermont Medicare beneficiaries by 2022.



- There are several targets associated with this agreement:
  - **Per capita health care expenditure growth rate** for all payers is limited to **3.5%.**
  - **Medicare per capita growth for Vermont Medicare beneficiaries** is limited to **0.1-0.2 percentage points** below that of projected national Medicare growth.
  - Quality targets set for substance use disorder, suicides, care of chronic conditions, and access to care.

Vermont's Per Capita Health Care Expenditure Growth Rate

- Modeled off the Medicare Next Generation ACO model.
- Medicaid contracts directly with the ACO on a shared risk basis (no Medicaid MCOs in VT).
- Dominant commercial insurer (> 80% market share) also contracted with the ACO.
- The growth is calculated as the compound annual growth rate over the five performance years of the agreement (2018-2022).
- The growth calculation is limited to expenditures on targeted services.

Sources: Fact Sheet – Vermont All-Payer ACO Model All-Payer Growth Financial Target, April 2017 and working knowledge of Vermont

Vermont's Targeted Services

Payer	Included Services	Excluded Services
Medicare	Medicare Parts A and B	Medicare Part D (retail Rx)
Medicaid	Most medical services Mental health paid for by the Medicaid agency Long-term institutional services (2021-2022)	Retail Rx Dental care Medicaid HCBS Medicaid mental health and substance abuse services funded by other state agencies Long-term institutional services (2018-2020)
Commercial	Most medical services	Retail Rx Dental care
Self-Insured	Most medical services	Retail Rx Dental care

Source: Fact Sheet – Vermont All-Payer ACO Model All-Payer Growth Financial Target, April 2017

Vermont
All-Payer Financial Growth Target

- While the goal for spending is 3.5%, there is some flexibility for unanticipated factors, including changes in Medicare law or local health or economic shocks.
- If Vermont's spending is over 4.3%, then Vermont is required to submit and implement a corrective action plan to get back on track.
- The ACO ensures financial target compliance by delegating significant risk to the participating hospitals in the form of a prospectively defined budget for total cost of care in the hospital's service area.

Sources: Fact Sheet – Vermont All-Payer ACO Model All-Payer Growth Financial Target, April 2017 and ACO state filing.

Planned Steering Committee Process for Developing Cost Growth Target Recommendations

- Our plan is to present the Steering Committee with a series of sequenced cost trend target design and implementation questions.
- We will in some cases present options for how Rhode Island could proceed, and draw from experience in Massachusetts, and to a lesser degree, Delaware.
- You will be asked to discuss the questions and provide your recommendations and rationale for the best course of action.
- While consensus would, of course, be ideal, we will not seek consensus if it is clear we lack agreement among steering committee members.

Total Health Care Costs

A cost growth benchmark is predicated on understanding what the total costs are on health care to be able to compare year-over-year change to the benchmark.

We therefore need to answer the following questions:

1. **Whose** health care costs are being measured?
2. Exactly **what** costs should be measured?
3. **Where** do the data come from?

Today, we will try to answer questions 1 and 2. During our next meeting, we'll address question 3.

Total Health Care Costs: Which Populations?

- To get a full picture of total health care costs in Rhode Island, it is important to gather cost data for as many populations as possible.
- When thinking about the populations to be included in the benchmark, there will be some data considerations for us to ponder. We will address those questions separately, yet systematically, in an upcoming meeting.
- For today, let's focus on which covered populations you think should be considered when calculating the health care cost growth benchmark.

Total Health Care Costs: Which Populations?

Medicare

- Medicare FFS (Parts A, B, D)
- Medicare Advantage

Medicaid

- Are there special populations that should be excluded?

Commercial

- Fully-Insured
- Self-Insured

Veterans Health Administration

FEHB

TRICARE

Correctional Health System

Are there any other populations we should consider for inclusion?
Data access will inform who can be included.

Total Health Care Costs: Which Populations?

- **Are there any populations that should be excluded?**

Possible Pros / Cons for Excluding Populations		
	Pros	Cons
Medicare	• Little state policy influence over Medicare.	• 13% of Rhode Islanders are Medicare beneficiaries
Medicaid	• None	• 17% of Rhode Islanders are Medicaid beneficiaries
Medicare and Medicaid Dually Eligible	• Less than 4% of the state's total population are dually eligible.	• While a small number, dually eligible beneficiaries incur about 50% of Medicaid spending
Commercial	• Need insurer cooperation • Data limitations may be significant for self-insured.	• Largest covered population within the state.

Total Health Care Costs: Which Populations?

- **Are there any populations that should be excluded?**

Possible Pros / Cons for Excluding Populations		
	Pros	Cons
Veterans Health Administration	• Data may be limited	• Veterans make up about 6% of the population of the state.
FEHB	• Less than 0.5% of Rhode Islanders are federal employees.	• None
TRICARE	• Less than 0.5% of Rhode Islanders are active members of the military.	• None
Correctional Health Care System	• Inpatient costs are already included under Medicaid's budget • 0.02% of Rhode Islanders are incarcerated • State spending for corrections is disaggregated and may be complex to obtain.	• Per inmate health care expenditures have risen 15%, though are still relatively low compared to commercial per capita health expenditures

Total Health Care Costs: What Costs?

Generally, there are two sets of costs to be measured:

1. claims-based costs
2. non-claims-based costs

- *Claims-based costs* are payments made on the basis of a specific claim for health care services.
- *Non-claims-based co*sts are payments not associated with a specific claim (e.g., capitation, P4P, shared savings distributions, infrastructure investments).

Typical Claims-Based Costs Include:

- Hospital inpatient
- Hospital outpatient
- Physicians
- Other professionals
- Home health and community health
- Long-term care
- Dental
- Pharmacy
- Durable medical equipment
- Hospice

Are there any services missing that should be captured in this list?

Total Health Care Costs: Claims-Based Costs

- **Are there any services that should be excluded?**

Possible Pros / Cons for Excluding Services		
	Pros	Cons
Hospital Inpatient / Outpatient Services	• None	• Largest costs in health care system
Physician and other professionals	• None	• Largest influencers of utilization in the health care system.
Home and community health	• None	• Important provider that will be taking on costs as health care shifts from less expensive sites of care.
Long-term care	• Primarily a Medicaid-funded service.	• A large percentage of the Medicaid budget.

Total Health Care Costs: Claims-Based Costs

- **Are there any services that should be excluded?**

Possible Pros / Cons for Excluding Services		
	Pros	Cons
Dental	• Not covered by commercial insurers as part of health care coverage, nor by Medicare. • Data may be difficult to obtain from commercial dental carriers.	• Covered by Medicaid. • Pediatric dental coverage is an essential health benefit. • Oral health is integral to overall health, and poor oral health can lead to poor general health, which could be costly.
Pharmacy	• High cost pharmaceuticals and patent- protected drugs new to the market can cause large variation in health care spending year to year.	• Not including pharmacy would leave out an important piece of health care spending, and the fastest growing component in recent years.
DME	• A small percentage of total spending.	
Hospice	• A small percentage of total spending.	

Total Health Care Costs: Non-Claims-Based Costs

Not all health care costs are captured through a claim. There are some non-claims costs that could be considered. For example:

- Performance incentive payments
- Prospective payments for health care services (e.g., capitation)
- Payments that support care transformation and infrastructure (e.g., care manager payments)
- Payments that support provider services (e.g., DSH payments)
- Prescription drug rebates / discounts
- Net cost of private health insurance (health insurer admin and margin/reserve contrib.)
- Patient cost sharing for eligible populations

- **Are there any costs missing that should be captured in this list?**
- **Are there any costs you think should be excluded?**

Public Comment Period

Wrap-Up and Next Meetings

All meetings are Mondays from 9:00 a.m.-12:00 p.m.

September 17	301 Metro Center Blvd, Suite 203, Warwick, RI 02886
September 24	Location TBD
October 15	301 Metro Center Blvd, Suite 203, Warwick, RI 02886
October 22	301 Metro Center Blvd, Suite 203, Warwick, RI 02886
November 5	301 Metro Center Blvd, Suite 203, Warwick, RI 02886
November 26	301 Metro Center Blvd, Suite 203, Warwick, RI 02886
December 10	301 Metro Center Blvd, Suite 203, Warwick, RI 02886