Rhode Island Health Care Cost Trends Steering Committee

SECOND MEETING, SEPTEMBER 17, 2018

Agenda

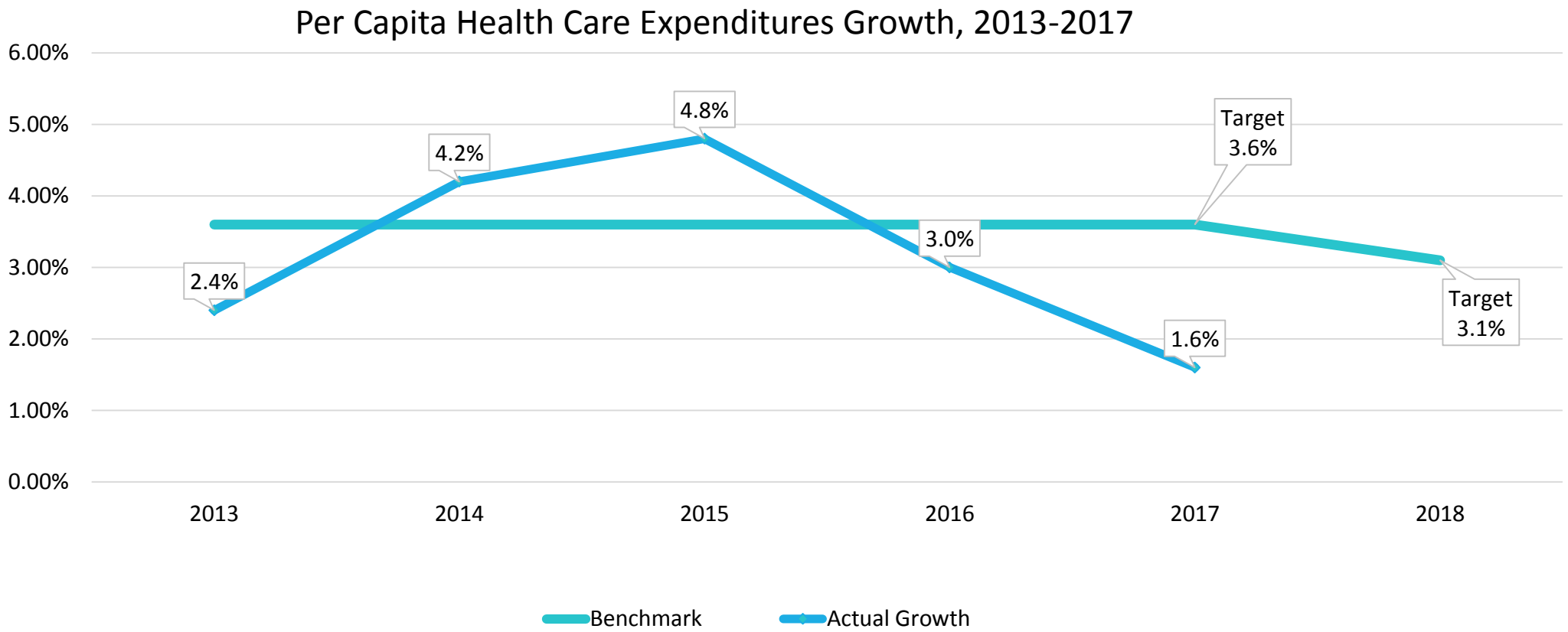
1.	Welcome and Follow-up from Previous Meeting	9:00 am – 9:15 am
2.	Cost Growth Target: Total Health Care Costs	9:15 am – 9:55 am
3.	Break	9:55 am – 10:05 am
4.	Cost Growth Target: Methodology for Target	10:05 am – 11:25 am
5.	Leveraging Multi-Payer Claims Databases for Value: Plans for the November 14th Data Use Strategies Conference	11:25 am – 11:45 am
6.	Public Comment	11:45 am – 11:55 am
7.	Next Steps and Wrap-up	11:55 am - noon

Follow-up Items From August 29

- **Materials:** The Steering Committee was provided with the following materials on 9/6:
  - a copy of the Peterson Grant award
  - the Delaware recommendation report to Governor Carney on establishing health care spending and quality benchmarks (targets)

- **Data Analysis Plan Feedback:**
  - Steering Committee members were to share recommendations for categories of medical spending with Megan Cole.
  - Steering Committee members were to let Megan Cole and Ira Wilson know if they were interested in looking at annual expenditures by different subgroups.

Hot off the Press: Massachusetts Experience



Sources: Center for Health Information and Analysis (CHIA) Performance of the Massachusetts Health Care System Annual Report, September 2018, September 2017, and September 2016; Total Health Care Expenditures from payer-reported data to CHIA and other public sources.

Recap: Total Health Care Costs

A cost growth target is predicated on understanding what are total health care costs. This allows for assessment of year-over-year change relative to the target.

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 finish up our discussions of 1 and 2. During a future meeting, we'll address question 3.

Recap: 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 target, 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 cost growth target.

Recap: 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

Correctional Health System

Are there any other populations we should consider for inclusion? Data access will ultimately inform who can be included. For now, please just communicate your preference.

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, and they account for a disproportionate % of spending
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 small in number, dually eligible beneficiaries incur about 50% of Medicaid spending
Commercial	Depending on data source: • may need insurer cooperation • data limitations may be significant for self-insured	• The 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.
Correctional Health Care System	• Inpatient costs are already included under Medicaid's budget • 0.02% of Rhode Islanders are incarcerated • Data access may be challenging	• Per inmate health care expenditures are relatively low compared to commercial per capita health expenditures

Total Health Care Costs: Which Populations?

One more consideration related to populations!

For the recommended populations:

1. What should be the residence of the patient?
2. What should be the location of their provider(s)?

*Remember, we're only talking about individuals covered by RI-licensed insurers. We can't capture data on RI residents covered by BCBSMA, for example.

Cost Growth Target Methodology vs. Study Population for Data Analysis

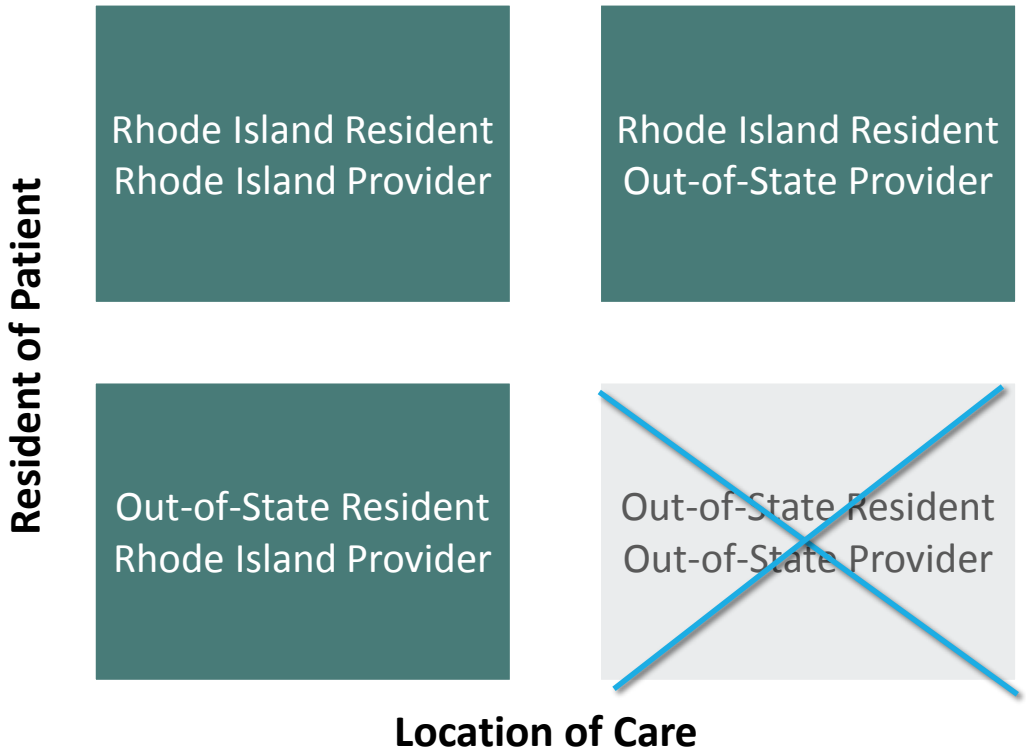
Brown's analysis of RI's APCD will include all Rhode Island residents, except

- those who receive the majority of their primary care outside of Rhode Island (if identifiable) and
- non-RI residents receiving care in RI.

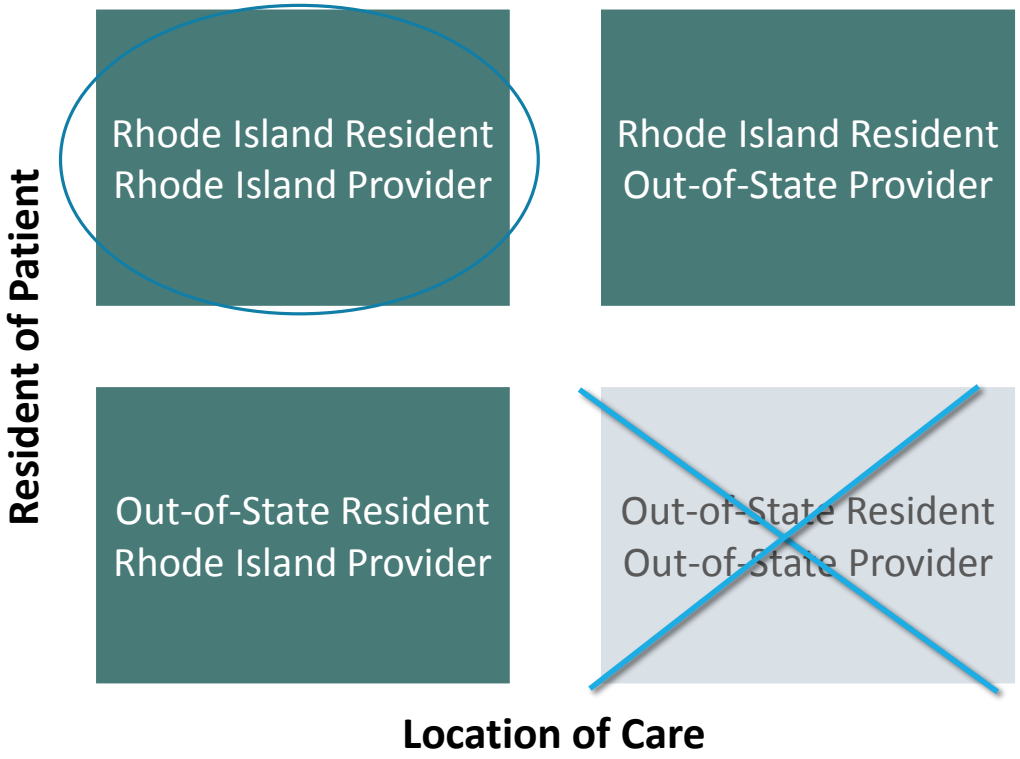
The methodology for the cost growth target does not need to be the same as that used in Brown's analysis of the APCD data.

- You may consider a different methodology because Rhode Islanders receiving most of their primary (and perhaps, other) care outside of the state may have costs that affect Rhode Island health insurance premiums.

State of Residence and Location of Care

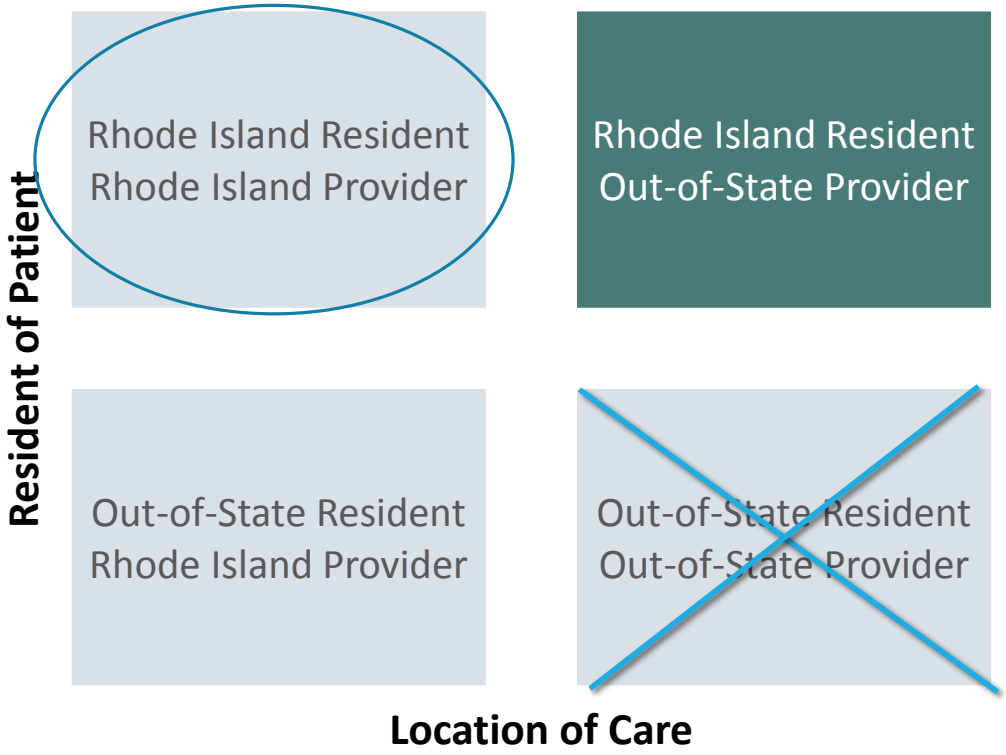


State of Residence and Location of Care



It's clear that we would want to include Rhode Island residents who received care from Rhode Island providers.

State of Residence and Location of Care



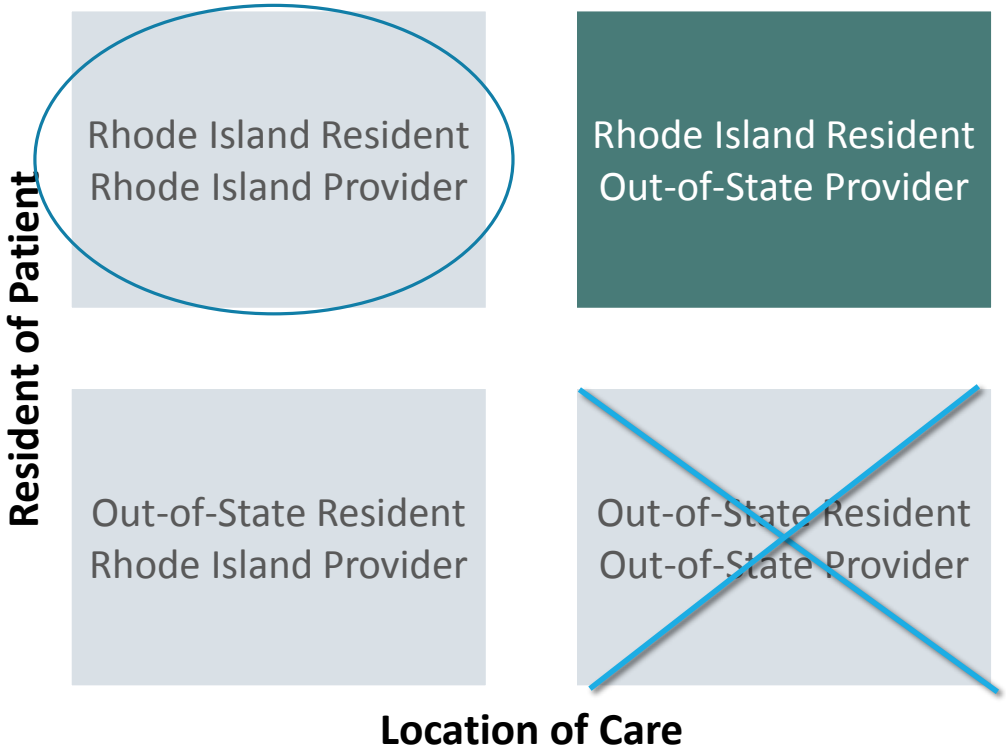
Should we include Rhode Island residents who received care from out-of-state providers?

This may be a consideration given the close proximity of most residents to another state.

If yes, should we include just bordering states? What about "snow birds" who travel to Florida or other parts of the country for part of the year?

Some health systems and ACOs have affiliation or employed physicians who are practicing in nearby states. Do we include these out-of-state providers if they care for RI residents?

State of Residence and Location of Care

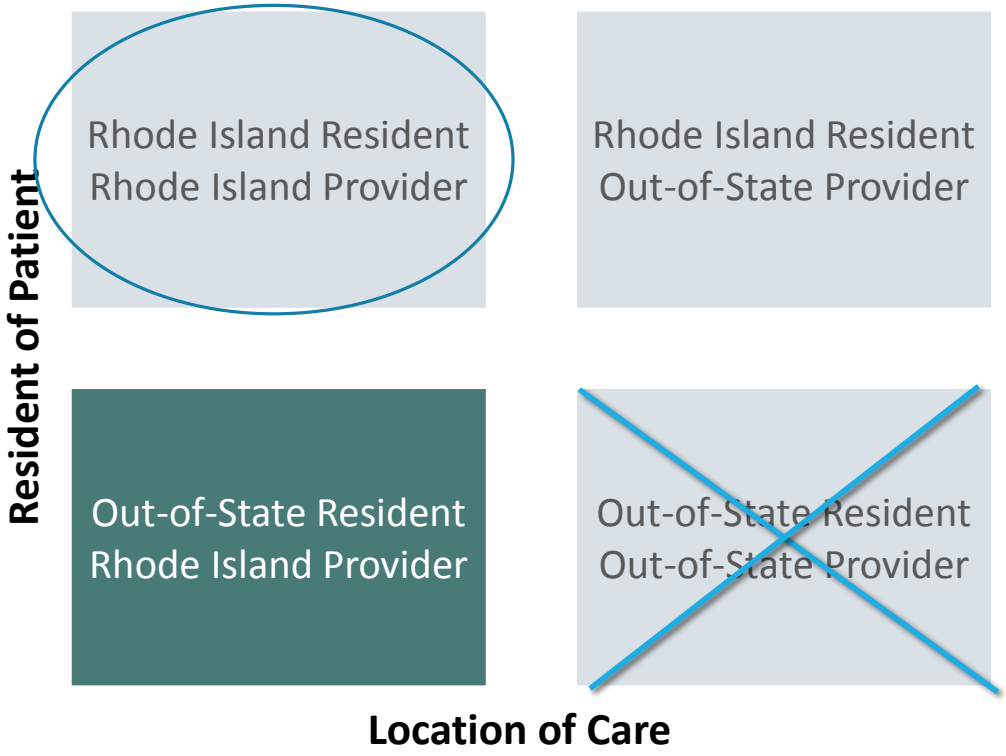


Rhode Island insurers should not have any difficulty in reporting these data from claims.

Medicare reports personal health care expenditures by state of provider and by state of residence.

Massachusetts does **not** include out-of-state residents in its denominator for its cost-growth target.

State of Residence and Location of Care



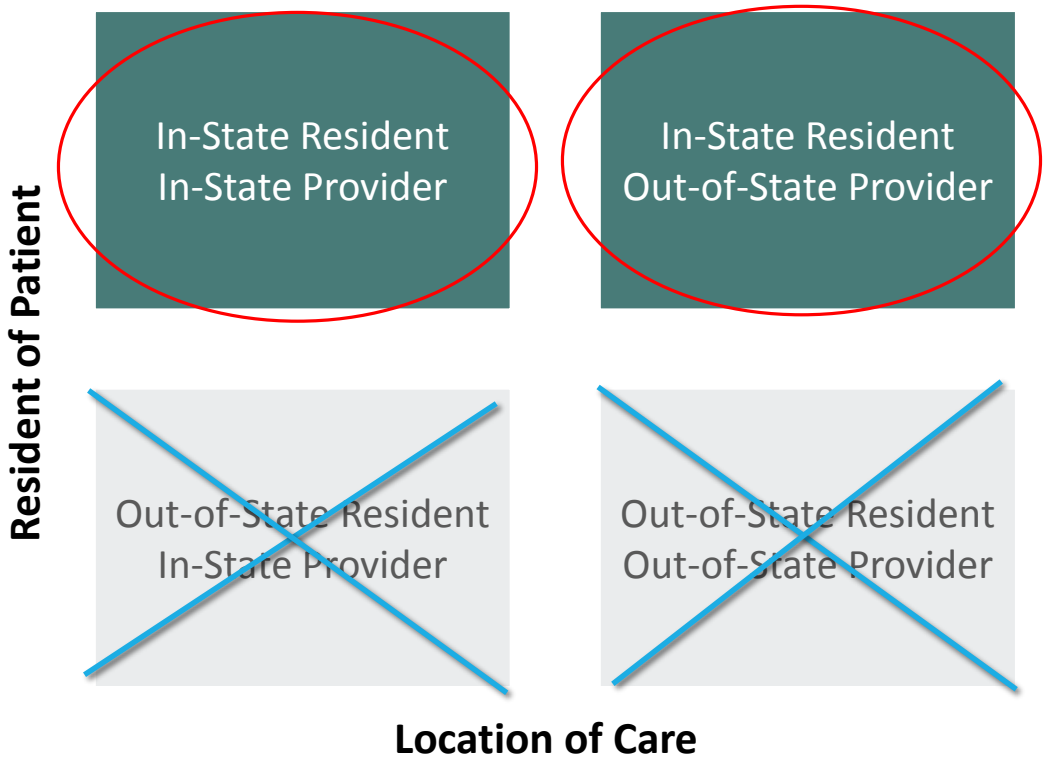
Should we include out-of-state residents who receive care by Rhode Island providers?

Because of those close borders, Rhode Island providers care for non-Rhode Island residents.

This might not be challenging for some insurers who have a presence in neighboring states, but may be so for insurers who do not have a large RI market.

Do we care about this spending since it is not RI spending and RI spending is our focus?

State of Residence and Location of Care: MA Approach and DE Recommendation



Massachusetts measures and Delaware recommends measuring the health care spending of all state residents, regardless of where they receive care.

Therefore, insurers report the total health care spending of each of their covered members who are in-state residents, even if they receive care in a neighboring state or elsewhere.

State of Residence and Location of Care Insurer and Employer Perspective

While intuitively it doesn't make sense to have non-RI residents seeking care from non-RI providers included, there are two wrinkles.

1. **Insurer Perspective**
   - Rhode Island-licensed insurers likely cover at least some individuals who do not reside in Rhode Island.
   - Should these individuals be included? Does it matter whether they seek care with Rhode Island providers or not?

2. **Employer Perspective:**
   - What about Rhode Island employers who pay for health care for employees who don't live in Rhode Island?
   - Should this be considered state spending if neither the patient nor provider resides in Rhode Island?

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 for Steering Committee consideration?

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	• Most significant costs in health care system
Physician and other professionals	• None	• Primary influencers of utilization of health care services.
Home and community health	• None	• Important provider as health care shifts from more 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: Claims-Based Costs MA and DE Approach

Massachusetts' insurers are required to report health care spending on the following:

- Hospital — Inpatient
- Hospital — Outpatient
- Professional physician
- Professional other — Services provided by licensed practitioners that are not physicians including, community health centers, freestanding ambulatory surgical centers, podiatrists, CRNPs, PT/OT, and more
- Prescription drugs
- Other — All other payments generated from claims, including SNF, home health, DME, hearing aids, etc.

Delaware has not developed the exact specifications of what insurers will need to provide, but intends to be expansive, like Massachusetts.

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, lump sum investments)
- Payments that support provider services (e.g., DSH payments)
- Prescription drug rebates / discounts
- Net cost of private health insurance (health insurer administration and margin/reserve contribution)
- 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?

Total Health Care Costs: Non-Claims-Based Costs MA and DE Approach

Massachusetts requires the following to be reported:

- **Non-claims incentive programs:** All payments made to providers for achievement relative to specific pre-defined goals for quality, cost reduction, or infrastructure development (e.g., P4P payments, EMR/HIT adoption incentive payments)
- **Capitation and risk settlements:** All payments made to providers as a reconciliation of payments made and payments made not on the basis of claims.
- **Care management:** All payments made to providers for providing care management, utilization review, discharge planning and other care management programs.
- **Other:** All other payments pursuant to a payer's contract with a provider that were not made on the basis of a claim for a medical services and not classified above, e.g., governmental payer shortfall payments, grants, or surplus payments.

Delaware has not developed the exact specifications of what insurers will need to provide, but intends to be expansive, like Massachusetts.

Two Complicating Circumstances (1 of 2)

Carveouts: Health insurers frequently administer plans with carveouts, most commonly for pharmacy and behavioral health services. Sometimes the carveout vendors contract directly with the self-insured employer.

- How should RI account for such benefit carveouts?

MA approach: Payers report partial claims data with respect to their carve-out benefit and the state contracts with an actuary to estimate the health care spending on carved-out services

Two Complicating Circumstances (2 of 2)

- **Prescription Drug Rebates:** Prescription drug rebates and other price concessions are commonly granted to pharmacy benefit managers and health insurers from drug manufacturers. The effect of these rebates is not clear on health care spending.
  - How should Rhode Island account for pharmacy rebates?

- **Massachusetts' approach:** M.G.L c. 12C requires consideration of the effect of drug rebates and other price concessions in the aggregate on health care spending growth trends.
  - Massachusetts requires payers to report on:
    - ✓ Pharmacy expenditures net of rebates,
    - ✓ Aggregate prescription drug rebates, and
    - ✓ Aggregate pharmacy expenditures (including member cost sharing and excluding rebates).
  - Rebates are reported separately and not part of the cost growth target.

- **Delaware's proposed approach:**

Delaware has proposed to include pharmacy spending net of rebates in the measurement of the state's per capita spending on health care.

Specifications have yet to be developed.

Two Complicating Circumstances

Possible Pros / Cons for Including Carveouts and Prescription Drug Rebates		
	Pros	**Cons**
Carveouts	• Not doing so would give an incomplete picture of commercial spending	• If RI adopted MA's approach to estimating carveout spending, it would be an added effort and expense for the State
Prescription Drug Rebates	• Pharmacy rebates are known to be substantive	• May be challenging to do • No precedence for including the effect of drug rebates in the total health care cost spending cost growth target calculation

Cost Growth Target Methodology

Cost Growth Target Methodology

The essential question is what will be the target growth rate?

There are a number of decisions to make including, will the target be:

1. Tied to one or more indices of economic growth, inflation or another economic indicator?
2. Adjusted? (inflated or deflated (+/-) by a certain number of percentage points)
3. Forecasted, historical or a blend of each?
4. Based on a multi-year approach (averaging or weighting years) or a single-year approach?

We'll review each one of these decisions individually.

Cost Growth Target Methodology

But first, let's…

- learn about the approaches used in other states, and in other applications, in Rhode Island, and
- develop criteria to guide decisions on developing a recommendation for a target.

Approaches Used in Other States (and in RI)

1. Massachusetts' and Delaware's (proposed) use of Potential Gross State Product
2. Washington's use of Gross State Product
3. Maine's use of a CPI-linked methodology
4. Rhode Island's use of a CPI-linked methodology

Massachusetts and Delaware Approach

Massachusetts set its cost growth target based on the potential gross state product (PGSP) and the Delaware Secretary of Health and Social Services recommends that DE do the same.

PGSP is a measure of the output of the economy. By using PGSP, both state's have set an expectation that health care spending should not grow faster than an estimate of the state's economic growth.

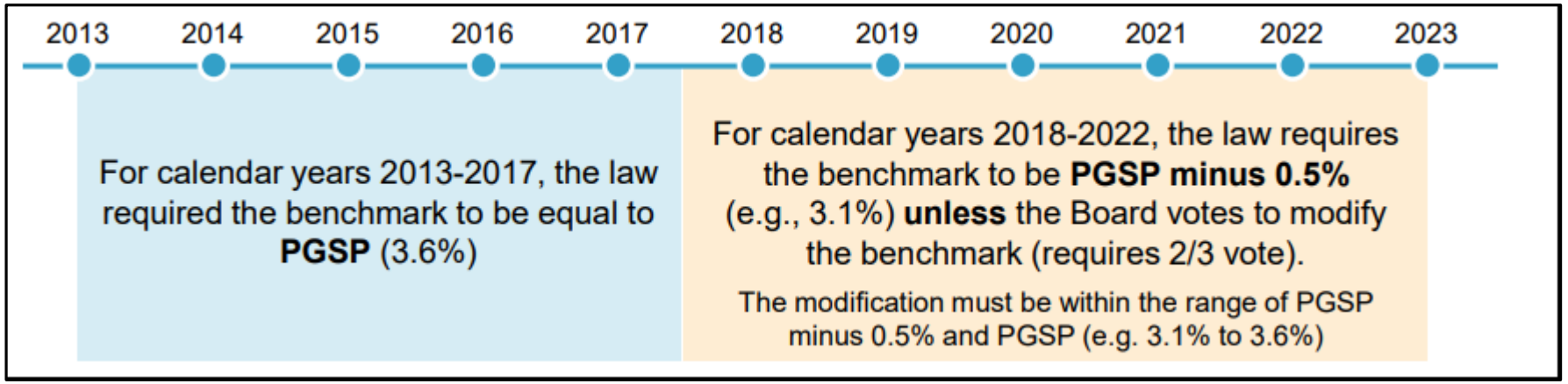
PGSP is calculated as follows:

(expected growth in national labor force productivity + expected growth in state civilian labor force + expected national inflation) – expected state population growth*

*This assumes that the state growth in labor force is equal to the national growth.

Massachusetts' Approach

In Massachusetts, the Secretary of Administration and Finance and the House and Senate Committees on Ways and Means jointly develop the PGSP value.



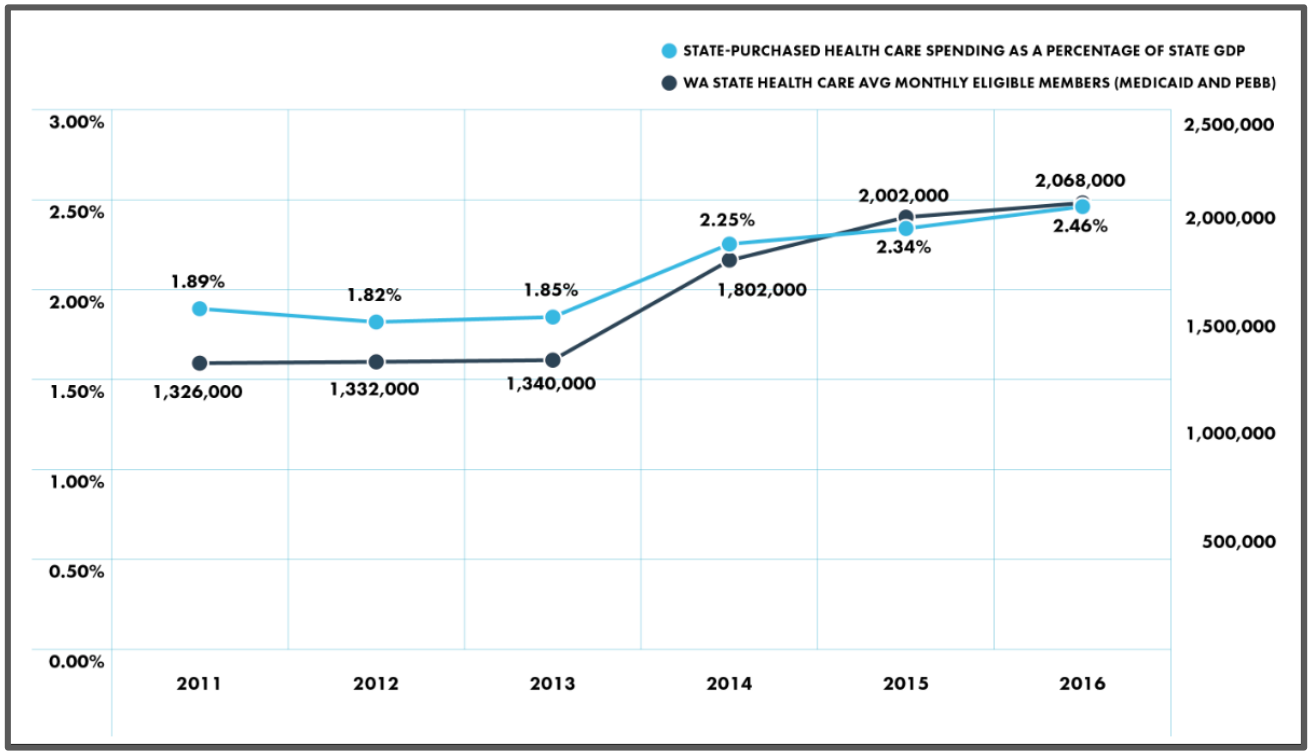
Delaware's Approach

Informed by Massachusetts, Delaware's Secretary of Health and Social Services has recommended that Delaware's cost growth target at the potential gross state product growth (PGSP) rate.

The recommendation is a calculation from publicly available data from sources such as the Congressional Budget Office and the Delaware Population Consortium.

Washington's Approach

Washington does not have a cost growth target, but it does measure *state-purchased* health care spending relative to actual GSP.



Source: Washington Community Checkup

Maine's Approach

As part of its SIM grant work, the Maine Health Management Coalition's Healthcare Cost Work Group developed a voluntary growth target to which ACOs would commit to keeping annual risk-adjusted, aggregate PMPM growth.

In Year 1, the target was set at the CPI-U for medical care.

Over the next four years, the target was set between CPI-U for medical care and the CPI-U less food and energy, gradually trending down in Year 5 to general CPI-U less food and energy plus 25% of the difference between the two indices.

The methodology was never implemented.

RI OHIC's Use of CPI

Regulation 2 sets forth rates which commercial insured hospital rates and population-based contract (ACO) budgets growth may not exceed. Both the hospital rate cap and the ACO budget growth cap are linked to CPI-U Less Food and Energy.

- For hospital rates, the cap is set at CPI-U Less Food and Energy +1%.
- For ACOs, the budget growth cap is set at CPI-U Less Food and Energy + an add on factor that declines annually.
  - 2015: +3.5%
  - 2016: +2.5%
  - 2017: +2.0%
  - 2018: +1.5%

While OHIC is using a measure of the economy, it is not the same application as other states. OHIC has established *caps* rather than *targets*.

Suggested Criteria for Cost Growth Target Methodology

1. Provide a predictable target
2. Adjust for the effects of changes in inflation
3. Rely on independent, objective data sources

Are there other criteria you wish to consider?

Cost Growth Target: Tied to Economic Growth or Inflation?

1. **Economic growth indicators:**
   - Rhode Island GSP
   - Rhode Island personal income

2. **Inflation indicators for the Northeast region:**
   - General inflation (Consumer Price Index for urban consumers (CPI-U))
   - CPI-U less food and energy
   - CPI-U less medical care
   - CPI-U medical care

Linking the Cost Growth Target to Economic Growth

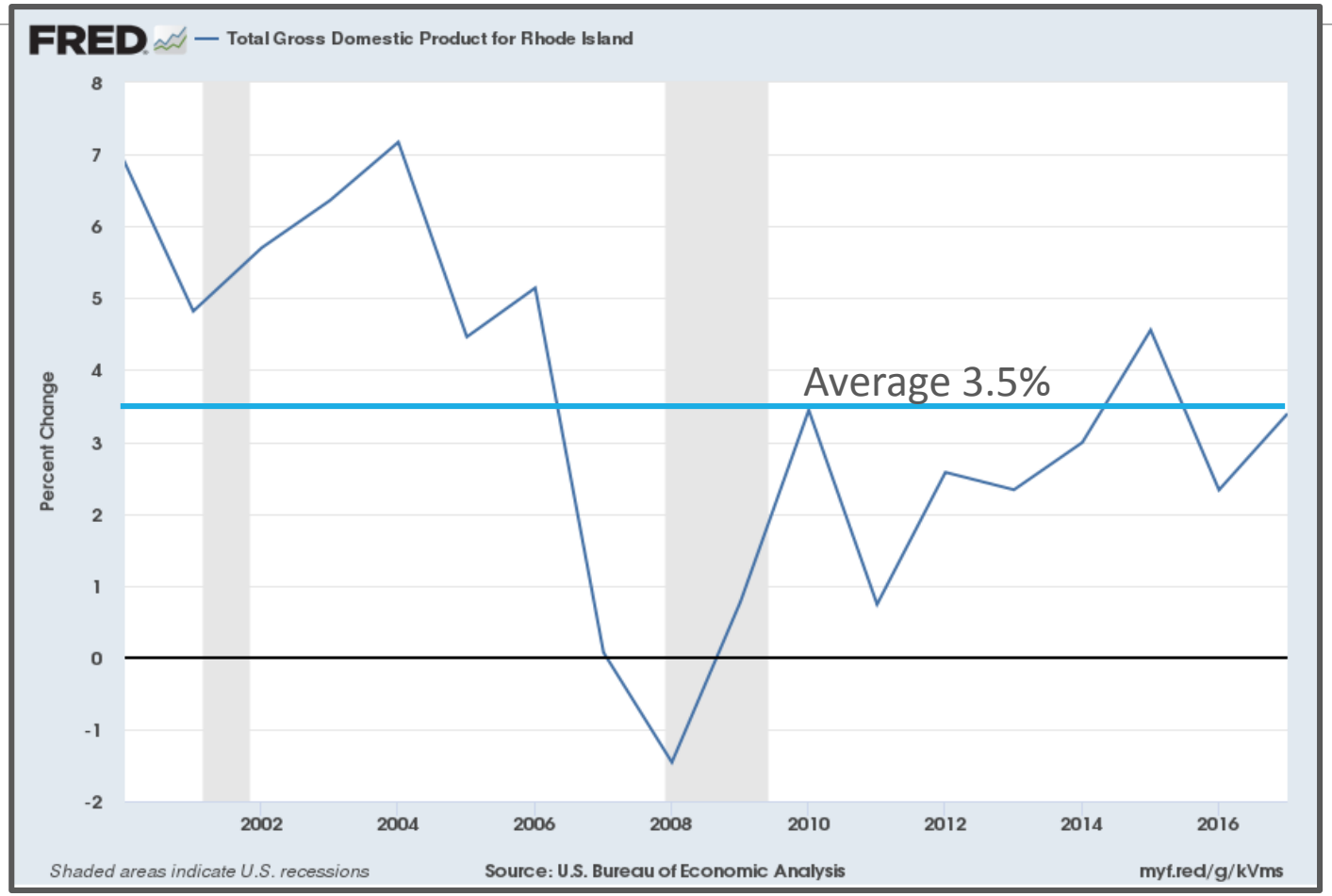
Generally, if the cost growth target is tied to economic growth, then the target would imply that health care should not grow faster than the economy.

Measures of Economic Growth:

- **State Gross Domestic Product (GSP):** the total value of goods produced and services provided in the state during a defined time period.
- **Personal Income Growth:** the total income received by, or on behalf of, all persons from all sources: wages, income derived from owning homes, businesses, from the ownership of financial assets (except realized and unrealized financial gains and losses), government sources (e.g., Social Security benefits) and employer benefits.
  - Wages and salaries account for about half of U.S. personal income.
  - States track personal income growth as a measure of a state's economic trends, as state revenue depends on personal income as does spending on government assistance programs.

Let's take a look at past rates of economic growth in Rhode Island, and past and projected rates of economic growth for the U.S.

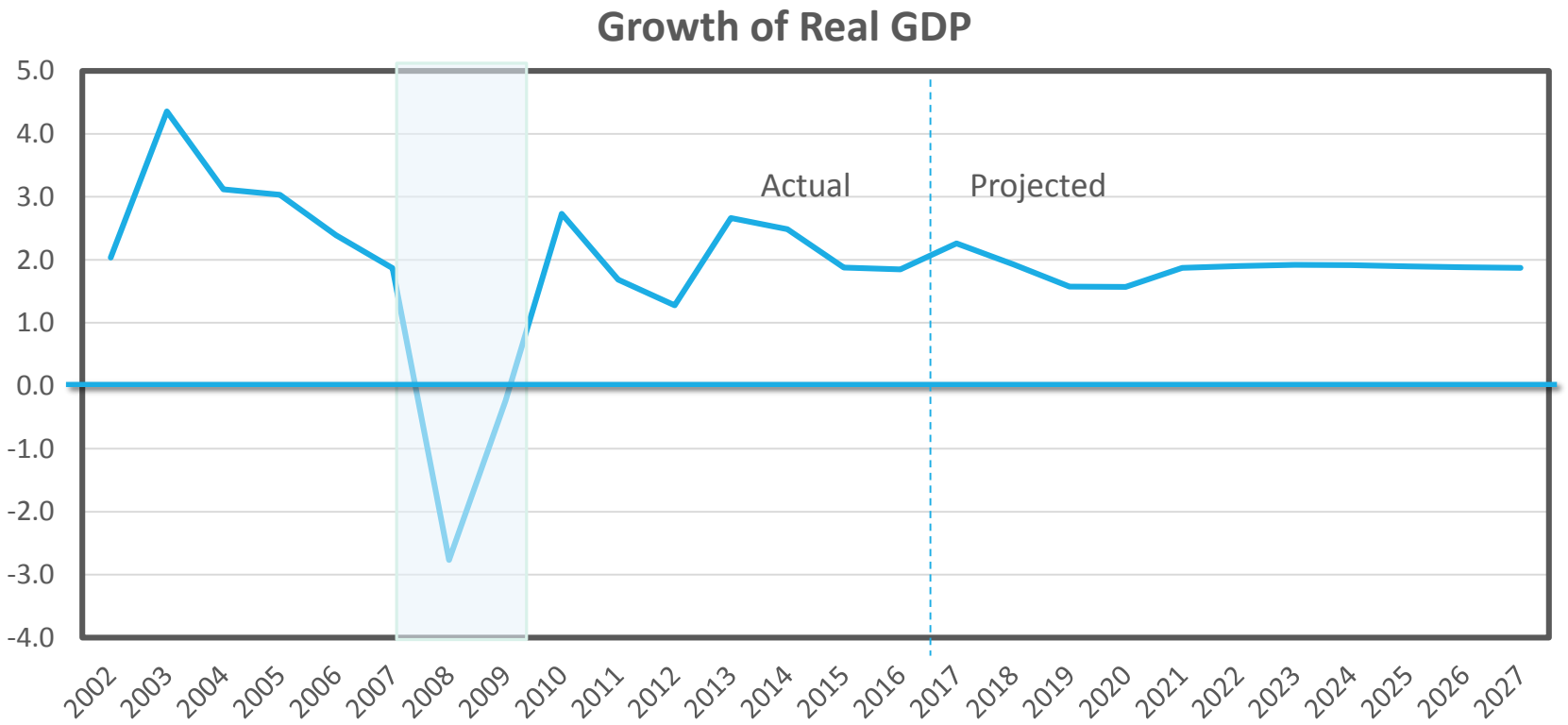
Total Gross State Product Growth Rhode Island 2000–2016



*Shaded areas denotes recession period

Source: U.S. Bureau of Economic Analysis, Total Gross Domestic Product for Rhode Island [RINGSP], retrieved from FRED, Federal Reserve Bank of St. Louis; https://fred.stlouisfed.org/series/RINGSP, August 20, 2018.

Real National Gross Domestic Product

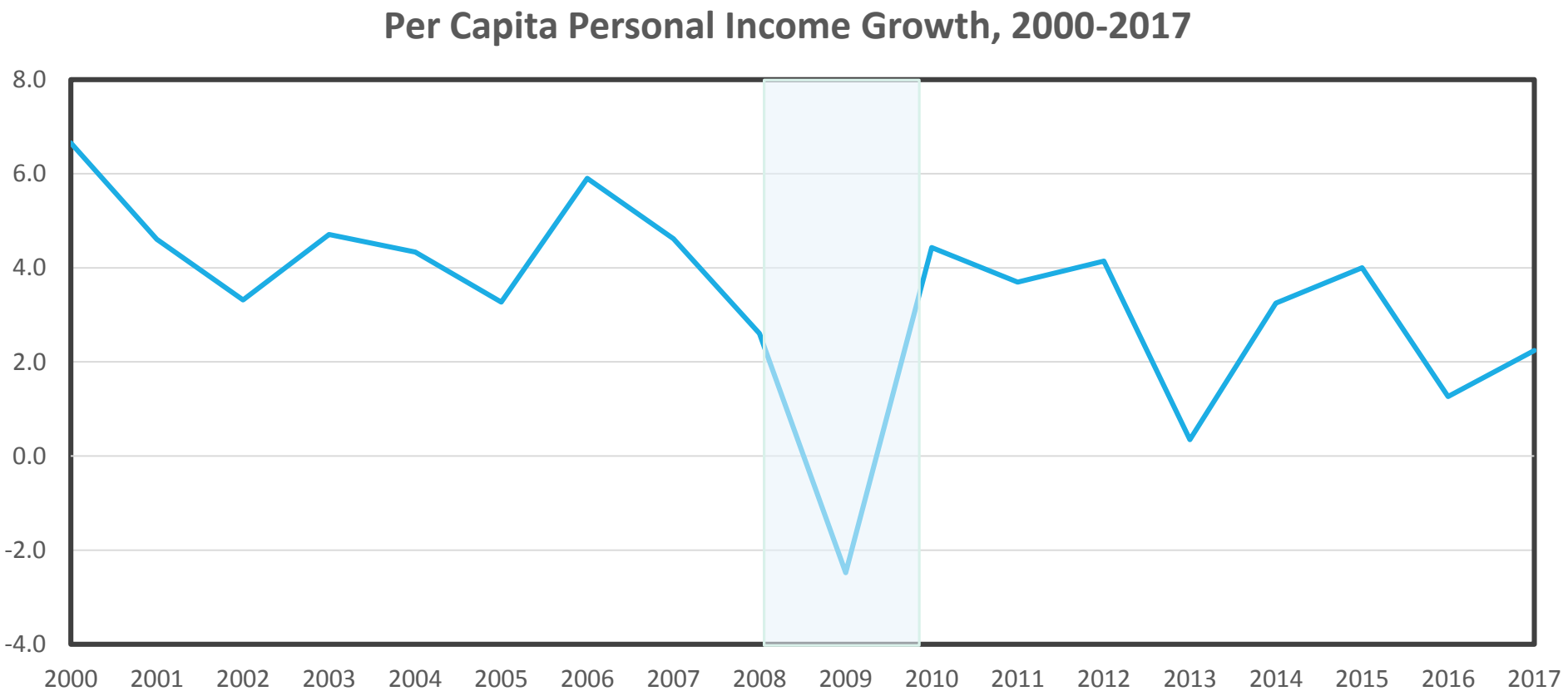


Real GDP is the output of the economy adjusted to remove the effects of inflation.

Shaded area denotes recession period.

Source: Congressional Budget Office; Bureau of Economic Analysis; https://www.cbo.gov/sites/default/files/115th-congress-2017-2018/reports/52370-supplementaldata.xlsx

Rhode Island Personal Income Growth



Source: Bureau of Economic Analysis

Considerations for Tying Target to Economic Growth

- Is tying health care spending to state economic growth — past or projected — or past personal income growth a good idea?
  - What would be the rationale for making the linkage to either?
- If it is a good idea, which of these options is preferable and why?
  - State economic growth?
  - State personal income growth?
- If it is a good idea, which of these options is preferable and why?
  - Average of past performance?
  - Projection of future performance?

Linking the Cost Growth Target to Inflation

Generally, if the cost growth target is tied to inflation, then the target would imply that health care should not grow faster than the average rise in consumer-paid prices.

How might inflation be measured?

Consumer Price Index: an index of the variation in prices paid by typical consumers for retail goods and other items. Specifically for food, clothing, shelter, fuel, transportation, medical care, prescription drugs and other goods and services that people buy for day-to-day living.

Consumer Price Index: Four Options

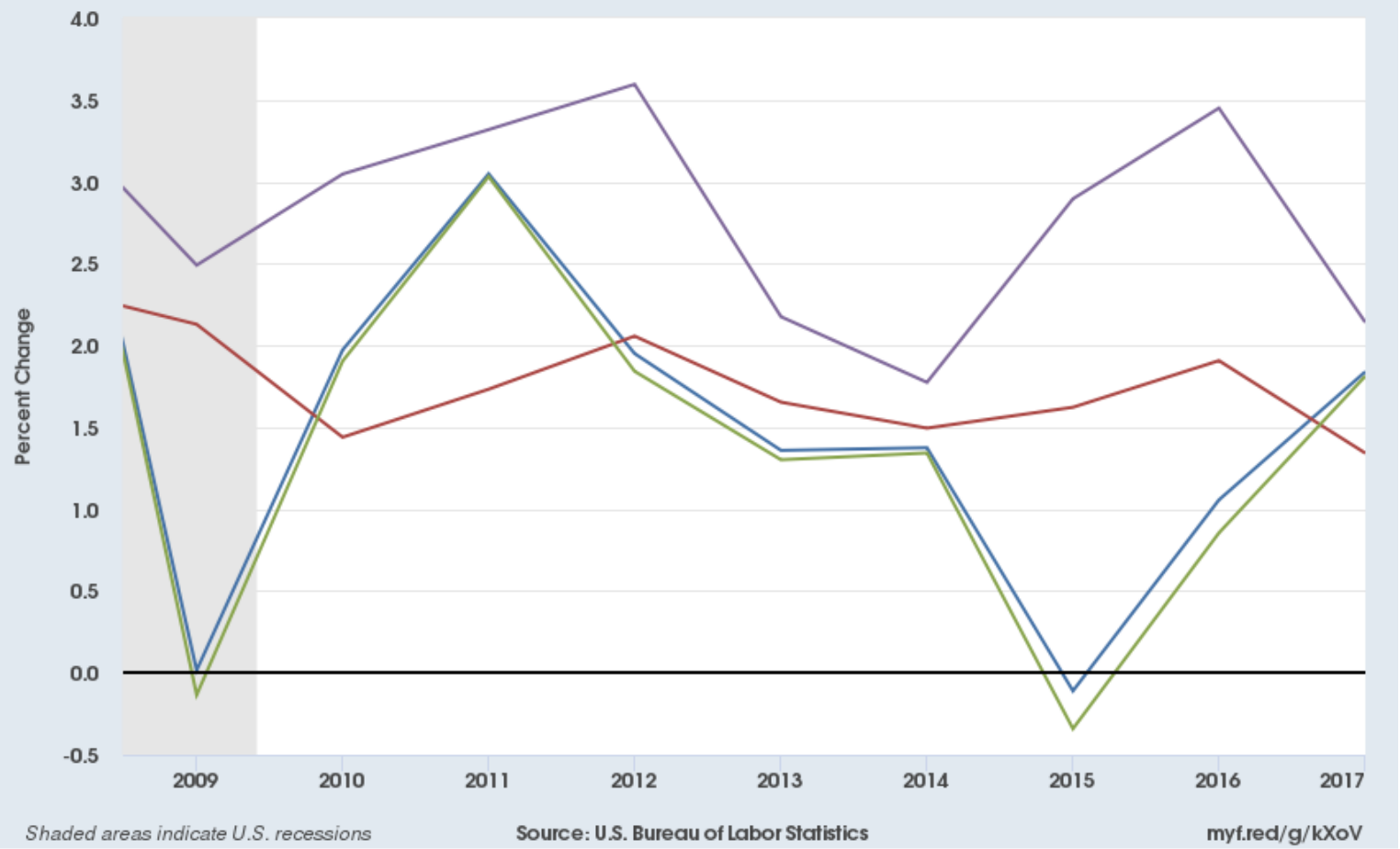
CPI-Urban, All Items (CPI-U): represents spending for about 94% of the total U.S. population of urban or metropolitan areas, including professionals, self-employed, low-income, unemployed and retired. Not included are farmers, people in the Armed Forces and those in institutions (e.g., prisons, mental hospitals).

CPI-U Less Food and Energy: removes food and energy prices from the calculation, as these prices are typically the most volatile

CPI-U Less Medical Care: removes medical care from the calculation, since the cost growth target is focused on medical care

CPI-U Medical Care: represents spending only on medical care services (professional, hospital and health insurance) and medical care commodities (Rx, DME)

Consumer Price Index: Four Options



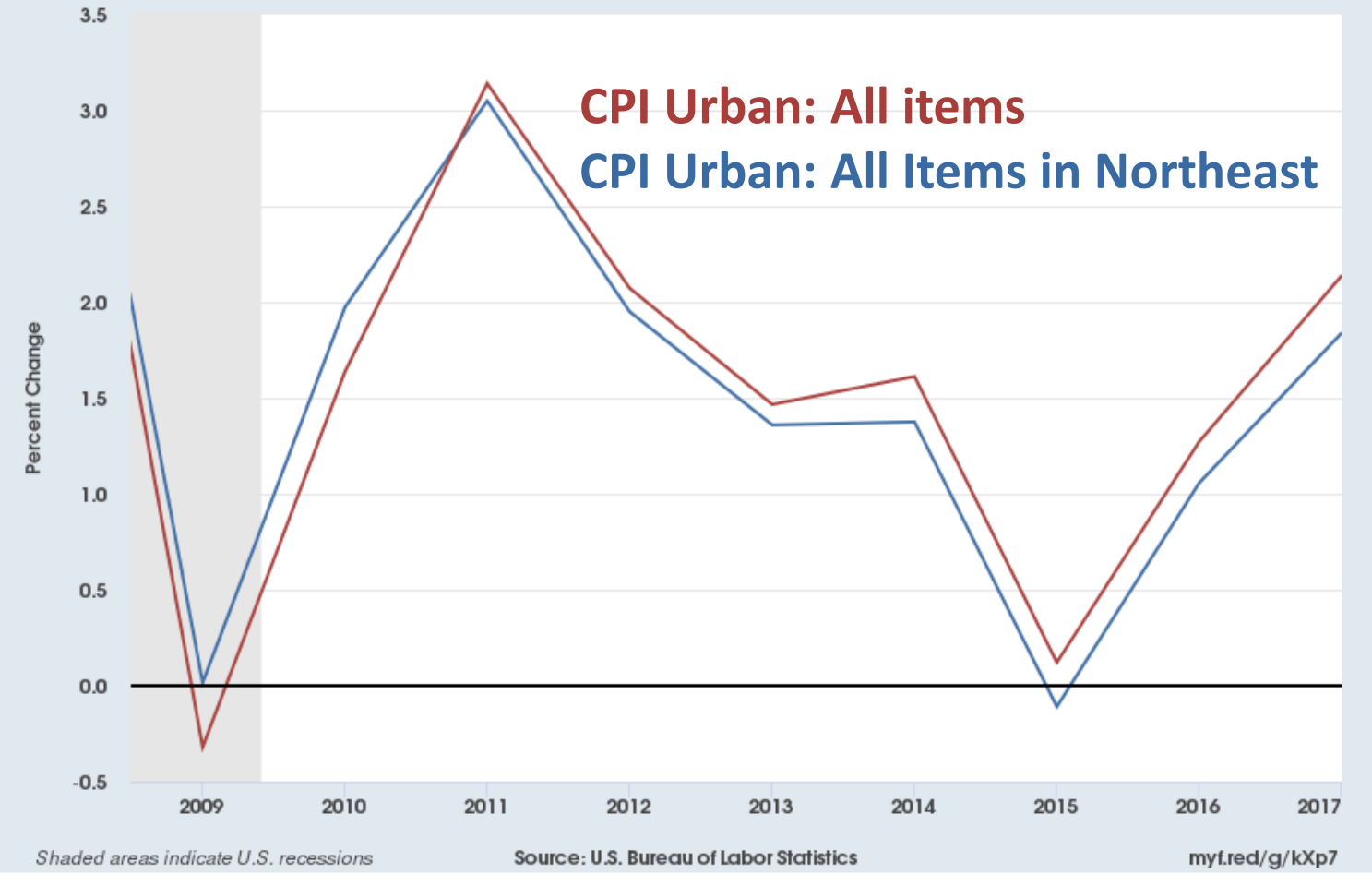
CPI-U: Medical care in Northeast

CPI-U: All Items in Northeast

CPI-U: All items less medical care in Northeast

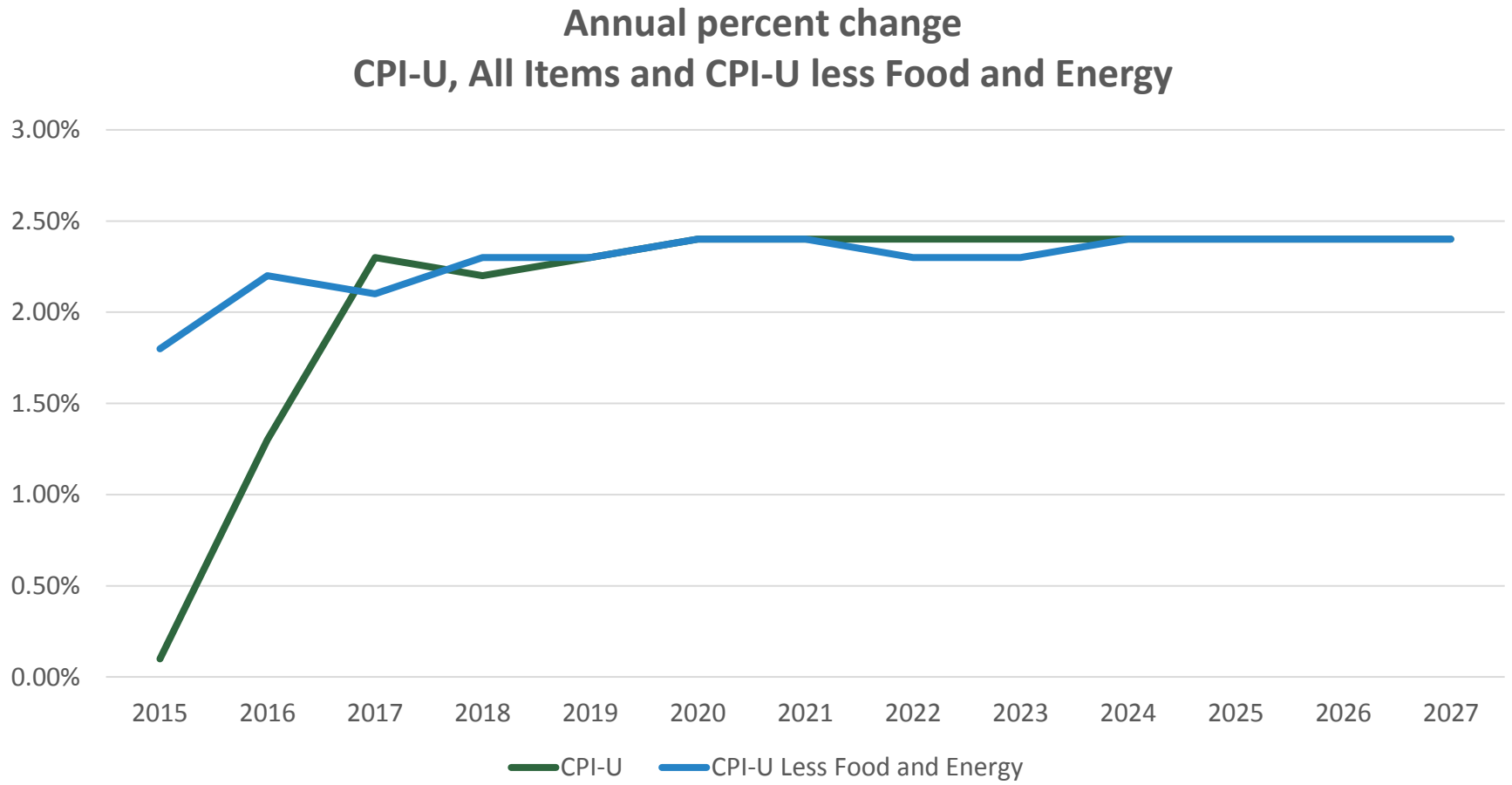
CPI-U: All items less food and energy in Northeast

Consumer Price Index: Northeast vs U.S.



- Rhode Island does not have its own market area where CPI is measured.
- The Northeast market includes CT, ME, MA, NH, NJ, NY, PA, RI and VT.
- More populous states like NY, NJ and PA drive the index.

National Consumer Price Index: Historical Values and Forecast



Source: CBO An Update to the Budget and Economic Outlook: 2017 to 2027 www.cbo.gov/publication/52801

Considerations for Tying Target to Inflation

- Is tying health care spending to consumer price growth — past or projected — a good idea?
  - What would be the rationale for making the linkage to CPI?
- If it is a good idea, which of these options is preferable and why?
  - CPI-Urban (CPI-U), all items?
  - CPI-U, less food and energy?
  - CPI-U, less medical care?
  - CPI medical care?
- If it is a good idea, which of these options is preferable and why?
  - Average of past performance?
  - Projection of future performance?

Economic Growth vs. Inflation

ECONOMIC INDICATOR	PROS	CONS
Gross State Product	• Sets expectation that health care shouldn't grow faster than the overall economy	• Consumers view health care cost as any other cost • Doesn't address high degree of waste in current spending
Personal Income	• Sets expectation that health care shouldn't grow more than personal income – a more consumer-centric concept than GSP	• Similar to Gross State Product • Does not capture all sources of personal income, e.g., capital gains
Consumer Price Index All Items	• Sets expectation that health care shouldn't grow faster than other consumer costs	• Assesses health care on price only and does not consider service volume
Consumer Price Index Less Food and Energy	• Same strengths as CPI All Items but much more stable	• Does not capture the significant effects of food and energy on consumer cost
Consumer Price Index Medical Care	• More generous to health care payers and providers, recognizing that, historically, health care cost growth has greatly exceeded CPI	• Use of this index would make the target methodology self-referencing • Does less to reduce spending on health care services based on historical experience

Additional Questions to Consider

- Now that we have had an initial discussion of economic indicators, we need to address two related questions:

1. Will the economic indicator(s) be adjusted (inflated or deflated (+/-) by a certain number of percentage points)?
2. Will it/they be based on a multi-year approach (averaging or weighting years) or a single-year approach?

Data Use Strategies

LEVERAGING MULTI-PAYER CLAIMS DATABASES FOR VALUE

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 and identify cost drivers

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

Save the Date!

- Leveraging Multi-Payer Claims Databases for Value Conference
- Wednesday, November 14, 2018
- Brown Faculty Club, Providence

Leveraging Multi-Payer Claims Databases for Value

- Meeting goal: To gain a broader understanding of actionable ways to use APCD data to measure and improve RI's health care system performance
  - A select group of states and organizations will share their data use strategies and experience.
  - Building on these learnings, discuss how RI can leverage its APCD to create better health care value.
- We'll have opportunities for facilitated and open discussion throughout the day.

Data Use Strategies and Invitees

Data Use Category	State/Organization Invitee
1. Support ongoing **regulatory activity and analysis** of potential policy initiatives	• New Hampshire Insurance Department ✓ • Oregon Health Authority ✓
2. Promote **transparency** for consumers and policymakers with **cost and quality reporting and tools**	• Massachusetts Center for Information and Analysis • Washington Health Alliance ✓
3. Support specific regional or provider-level **delivery system** activity	• Vermont Blueprint for Health ✓

Additional Invitees

- Additional subject matter experts from outside of the state
- Other RI stakeholders
- Peterson Foundation attendees, including Executive Director Jay Want

Proposed Agenda

- November 14, 2018 | 8:00 a.m. – 3:30 p.m.

- **Morning**: We will hear from speakers about their strategies, impact, lessons learned, etc. After each group of speakers, there will be a moderated discussion and facilitated Q&A.
- **Afternoon**: Moderated panel discussion about how providers, payers and / or the State leverage RI's APCD to enhance the value of health care.

Next Steps: Date Use Strategies

- Questions or suggestions?
- We invite you to think about questions you would like to ask or topics you would like to discuss at the meeting
- There will be open Q&A but if you'd like to prepare questions in advance for moderated discussions, please send them to Justine (jzayhowski@bailit-health.com)

Public Comment Period

Wrap-Up and Next Meetings

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

September 24	1511 Pontiac Ave, Bldg. 73, Cranston, RI 02920
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