Rhode Island Health Care Cost Trends Project

Steering Committee Meeting Summary
301 Metro Center Blvd., Suite 203, Warwick
October 15, 2018
9:00am – 12:00pm

Steering Committee Attendees:
Al Charbonneau, Rhode Island Business Group on Health
Jim Fanale, Care New England
Stephen Farrell, UnitedHealthcare of New England
Marie Ganim, Co-chair, Office of the Health Insurance Commissioner
Peter Hollmann, Rhode Island Medical Society
Kim Keck, Co-chair, Blue Cross Blue Shield of Rhode Island
Al Kurose, Co-chair, Coastal Medicine
Teresa Paiva Weed, Hospital Association of Rhode Island
Betty Rambur, University of Rhode Island College of Nursing
Sam Salganik, Rhode Island Parent Information Network
John Simmons, Rhode Island Public Expenditure Council
Neil Steinberg, Rhode Island Foundation
Larry Wilson, The Wilson Organization
Dan Moynihan, Lifespan (for Tim Babineau)
Beth Marootian, Neighborhood Health Plan Rhode Island (for Peter Marino)

Steering Committee Members Unable to Attend:
Tim Babineau, Lifespan (sent a representative)
Adriana Dawson, Bank Newport
Chris Koller, Milbank Memorial Fund
Peter Marino, Neighborhood Health Plan Rhode Island (sent a representative)

Steering Committee Staff Attendees:
Cory King, Office of the Health Insurance Commissioner
Kim Paull, Executive Office of Health and Human Services
Anya Rader Wallack, Brown University
Ira Wilson, Brown University
Michael Bailit, Facilitator, Bailit Health
Megan Burns, Bailit Health
Justine Zayhowski, Bailit Health

Welcome

- Kim Keck announced the participation of two new Steering Committee members: Tom Croswell and Peter Marino. Peter Marino was represented during the 10/15 meeting by Beth Marootian.
- Marie Ganim reminded Steering Committee members to RSVP to the November 14th conference, *Leveraging Multi-Payer Claims Databases for Value*, if they had not yet done so.
    - **Action step:** Bailit Health will provide Steering Committee members with information about conference parking.

Follow-up Topics from Previous Meetings

- **Out-of-state residents with RI providers:**
    - **Decision**: Exclude out-of-state residents with Rhode Island providers from the target calculation given that: 1) the population is small and believed to not have unique characteristics, and 2) there is administrative burden associated with collecting data on this population.
- **Pharmacy rebates:** The Steering Committee wanted to include pharmacy rebates in the spending calculation, as rebates have a significant impact on spend. Despite their importance, some noted that there could be difficulty reporting pharmacy rebates.
    - **Decision:** The cost growth target should include rebates as an administrative expense using a methodology that is not overly burdensome.
- **How to capture "spending" by individuals without insurance:** The Steering Committee discussed difficulties capturing the spending of the uninsured and the high costs associated with seeing these patients in certain settings, such as the emergency department. The Steering Committee noted the small population size of the resident uninsured (~1.5%) as compared to other populations that the Steering Committee already decided to exclude (e.g., Veteran's Health Administration).
    - **Decision:** Exclude provider costs associated with persons without health insurance from the health care spending calculation. Include in the health care spending methodology decision an affirmative statement recognizing that the cost growth target does not include the costs incurred by the uninsured.
- **Spending growth target vis-à-vis OHIC's hospital rate and ACO budget caps:** Megan Burns noted that OHIC previously implemented hospital rate and ACO budget growth caps in its Affordability Standards. These caps are focused on particular elements of health care spending specific to commercial fully-insured populations. The cost growth target being developed by the Steering Committee is not inconsistent with the OHIC rate caps and could use a different economic index, as the cost growth target is focused on total health care spending for all payers and the rate caps focus on commercial insurance. In addition, she noted that the OHIC caps can help insurers meet the statewide cost growth target.
- **Co-chair recommendation of the cost growth target index:** The co-chairs recommended tying the cost growth target to the potential gross state product (PGSP). PGSP is most closely aligned with the goal of this work – to reduce growth in health care costs and state health care spending. PGSP estimates the growth of the entire

economy, which encompasses growth in personal income and business growth. Tethering health care spending growth to state economic growth means that health care will no longer represent an ever-increasing portion of the economy.

The Steering Committee agreed with the recommendation. Some Steering Committee members expressed concern that the cost growth target could encourage OHIC to adjust the hospital rate cap if the state was not meeting the cost trend target. Some Steering Committee members noted that Rhode Island could meet the cost growth target, but still not have affordable health insurance.

- **Decision:** The Steering Committee selected PGSP as the economic index for the cost growth target.
- **Action step:** Bailit Health will share the value of PGSP at the next meeting so the Steering Committee is aware of the value when deciding if it wants to make an adjustment in the value of the cost growth target.

Cost Growth Target Performance Assessment: Data Sources

- The Steering Committee discussed three potential data sources for the cost growth target performance assessment: 1) HealthFacts (APCD), 2) OHIC, or 3) payers. Michael Bailit reviewed whether each potential source included data on claims-based payment for the fully insured and self-insured, non-claims-based payment, the net cost of health insurance, and pharmacy rebate.
- Steering Committee members observed the challenges of using the APCD to calculate performance of the cost growth target, at least at the project's outset, due to: 1) missing data for the self-insured (the APCD only contains 47% of the self-insured market per EOHHS analysis) and non-claims-based payments.
- The Steering Committee acknowledged that use of either the APCD or payer reported data was associated with administrative costs to both the state and payers.
- Kim Paull encouraged further development of the APCD to support cost growth target performance assessment. She said that this project could help provide momentum to adapt the APCD to incorporate missing data elements.
  - **Decision:** The Steering Committee decided to use payer-reported calculations to assess performance against the cost growth target, at least initially. In the future, the state may consider using APCD data once the APCD contains more self-insured data and non-claims-based payments.

Cost Growth Target: Provider Attribution and Risk Adjustment

- **Attribution methodology:** The Steering Committee discussed two approaches to patient attribution: 1) patients are attributed using a common methodology, or 2) patients are attributed using each payer's own attribution methodology.
  - **Decision:** The cost growth target will use existing payer attribution methodologies to avoid the need for additional payer work.
- **How many attributed patients must a provider have for its spending growth rate to be calculated:** While Massachusetts calculates target performance for providers covering 3,000 lives, the project team recommended setting a 10,000-lives threshold (consistent

with OHIC's threshold for ACO Minimum Downside Risk requirements) to ensure statistically robust results and to reduce the resources required for analytic activity.
    - Some Steering Committee members noted that many groups would fall below the threshold, leaving data only on three to four Rhode Island providers.
        - The Steering Committee members wondered if there was value including smaller groups and if their spending could be reported in aggregate.
            - Kim Keck noted that the large providers are already managing risk, while the remaining providers are not.
        - Al Kurose said including providers with a small number of covered lives could be misleading as the general public may not understand that changes in spending could be due to random variation.
        - Tom Croswell recommended developing action plans in aggregate and at the provider level.
    - Some Steering Committee members wondered whether there was a significant difference in employing a 5,000-lives and 10,000-lives threshold.
    - **Action steps:**
        - Steering Committee members will further consider their recommendation for the membership threshold.
        - Bailit Health will see if it can share information on the impact of random variation from an analysis it performed for a large Medicaid plan.
        - Bailit Health will ask payers how many provider contracts have 5,000 or 10,000 attributed lives.
- **Attribution to whom:** The Steering Committee discussed which types of providers should be included in patient attribution: hospitals and health systems, 2) medical groups with primary care, including FQHCs, 3) IPAs, and/or 4) ACOs. Michael Bailit asked the Steering Committee if it recommended using the ACO contracting unit or the provider-corporate entity as the primary unit of analysis.
    - Some Steering Committee members recommended using the ACO contracting unit but noted that this could be difficult operationally as provider participation could vary contract to contract.
    - **Action step:** Tom Croswell, Stephen Farrell, Kim Keck, and Beth Marootian will consider the operational implications of reporting patient attribution by ACO and come prepared to discuss their findings at the next meeting.

Interest in Establishing Quality Targets:

- Michael Bailit asked the Steering Committee if it was interested in establishing quality targets, as had been suggested by some members during prior meetings. Some Steering Committee members stated that quality is already publicly reported through existing processes, and while important, is out of scope for the current discussion. Other Steering Committee members wanted to establish measures focused on improving population health outcomes and reducing waste in the health care system.

- **Decision:** The Steering Committee will not pursue quality targets at this time. In the future, the Steering Committee will discuss improving population health outcomes and reducing waste in the health care system.

Public Comment:

- Pano Yeracaris shared that the annual conference of the Care Transformation Collaborative (CTC-RI) is coming up on 11/1. For more information, please visit the event's website: www.eventbrite.com/e/2018-ctc-ri-annual-conference-building-capacity-for-comprehensive-primary-care-tickets-48802157567.

Next Steps and Wrap-Up:

- The next Steering Committee meeting will take place on 11/5 from 9am-12pm at 301 Metro Center Blvd, Suite 203 in Warwick. The Steering Committee will begin by discussing risk-adjustment and the cost growth target implementation timeline. The Steering Committee will also discuss how performance will be reported and preview the November data use strategy conference, *Leveraging Multi-Payer Claims Databases for Value*.