Rhode Island Health Care Cost Trends Steering Committee

FOURTH MEETING, OCTOBER 15, 2018

Agenda

1.	Welcome	9:00 am – 9:05 am
2.	Follow-up from Previous Meetings	9:05 am – 9:45 am
3.	Cost Growth Target Performance Assessment: Data Sources	9:45 am – 10:40 am
4.	Break	10:40 am – 10:50 am
5.	Cost Growth Target: Provider Attribution and Risk Adjustment	10:50 am – 11:20 am
6.	Cost Growth Target: Timeline	11:20 am – 11:35 am
7.	Interest in Establishing Quality Targets	11:35 am – 11:45 am
8.	Public Comment	11:45 am – 11:55 am
9.	Next Steps and Wrap-Up	11:55 am - Noon

Reminder: Please RSVP!

If you have not done so already, please email Justine Zayhowski (jzayhowski@Bailit-health.com), to let us know if you can attend.

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

Proposed Agenda

- **Data Use 1: Support ongoing regulatory activity and analysis of potential policy initiatives.**
  - Tyler Brannen, New Hampshire Insurance Department
  - Stacey Shubert, Oregon Health Authority
- **Data Use 2: Promote transparency for consumers and policymakers with cost and quality reporting and tools.**
  - David Auerbach, Massachusetts Health Policy Commission
  - Nancy Giunto, Washington Health Alliance
- **Data Use: 3: Support specific regional or provider-level delivery system activity.**
  - Mary Kate Mohlman, Vermont Blueprint for Health
- **Afternoon**: Moderated panel discussion about how providers, payers and / or the State leverage RI's APCD to enhance the value of health care.

Reminder: Why Are We Here?

The vision for this project is to provide Rhode Island citizens with high-quality, affordable health care. The Peterson grant application further states that the purpose of this project is to reduce growth in health care costs and state health care spending.

Please continue to keep this in mind as we continue our conversation…

Meeting Reminder: Project Foci

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

These are two independent projects that have some similar and related decisions to make. Their design parameters need not be the same.

Recommendations You Have Made So Far

The Steering Committee has made several recommendations thus far on the methodology for assessing total health care spending and how performance relative to a target will be assessed. Decisions on other topics are still being formulated.

Total Health Care Spending Definition

- **Payers**: Commercial (fully and self-insured), Medicaid and Medicare spending.
- **Population**: RI residents receiving care from in-state and out-of-state providers. *Undecided: out-of-state residents with RI providers (to be discussed today).*
- **Spending:** Claims-based spending, non-claims-based spending and net cost of private health insurance. *Undecided: how to account for pharmacy rebates (to be discussed today).*

Target Performance Assessment Method

- **Level of Performance Reporting:** State-level, insurance market level, insurer level, and provider level. *Undecided: attribution size and risk-adjustment methodology for performance at the provider level (to be discussed today).*

Follow-up on Topics from Prior Meetings

- Out-of-State Residents with RI Providers
- Pharmacy Rebates
- “Spending” by Individuals without Insurance
- Co-Chair Cost Growth Target Index Recommendation

Out-of-State Residents with RI Providers

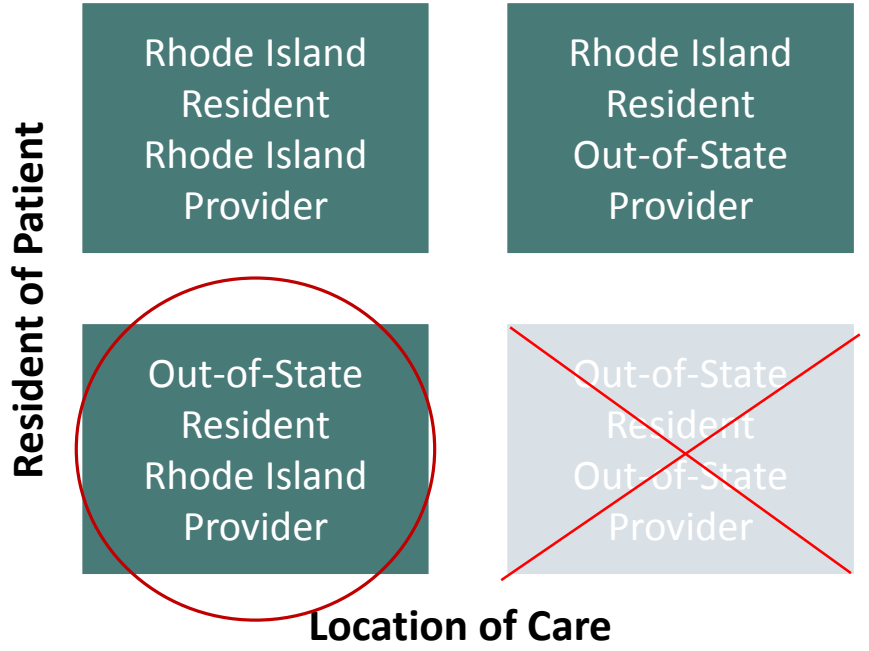
During the September 17 meeting, we discussed the spending on which populations will be considered in the cost growth target.

We were undecided on out-of-state residents who seek care from RI providers.

The Steering Committee was leaning toward including this population, but wanted to confirm whether Medicare data would be available.

The data Massachusetts receives comes from the Medicare Chronic Condition Database. Within the database, Provider NPI are captured, so it is likely a matter of making the data request specific enough for Medicare's data warehouse to capture all spending in the state.

Given this, does the Steering Committee wish to recommend inclusion of spending for out-of-state residents using Rhode Island providers?



Pharmacy Rebates

During our 9/17 meeting we identified a complication to calculating total health care spending: the effect of pharmacy rebates and whether they should be accounted for in the calculations.

Reminders:

- Drug manufacturers are mandated by law to provide Medicaid with rebates for certain drugs.
- Drug manufacturers also negotiate with PBMs to provide discounts to commercial payers. Commercial payers sometimes receive these rebates.

What does it mean to "include" pharmacy rebates in the total spending calculations?

- It means recognizing that the rebates are *significant* in amount and they *lower* the spending that would otherwise be included in total health care spending.
- In Massachusetts, insurers must report rebate values. MA reports Total Health Care Expenditures (the measurement of spending at the state level) net of rebates. MA reports Total Medical Expense (which is used to assess spending at the market, insurer and provider levels) gross of rebates.

Pharmacy Rebates

What's the rub?

1. Rebate data is administratively difficult to apply below the payer level and the value of rebates could only be incorporated into the calculation of state-level spending and insurer-level spending growth, but not into calculation of provider-level spending growth.

Questions for the Steering Committee:

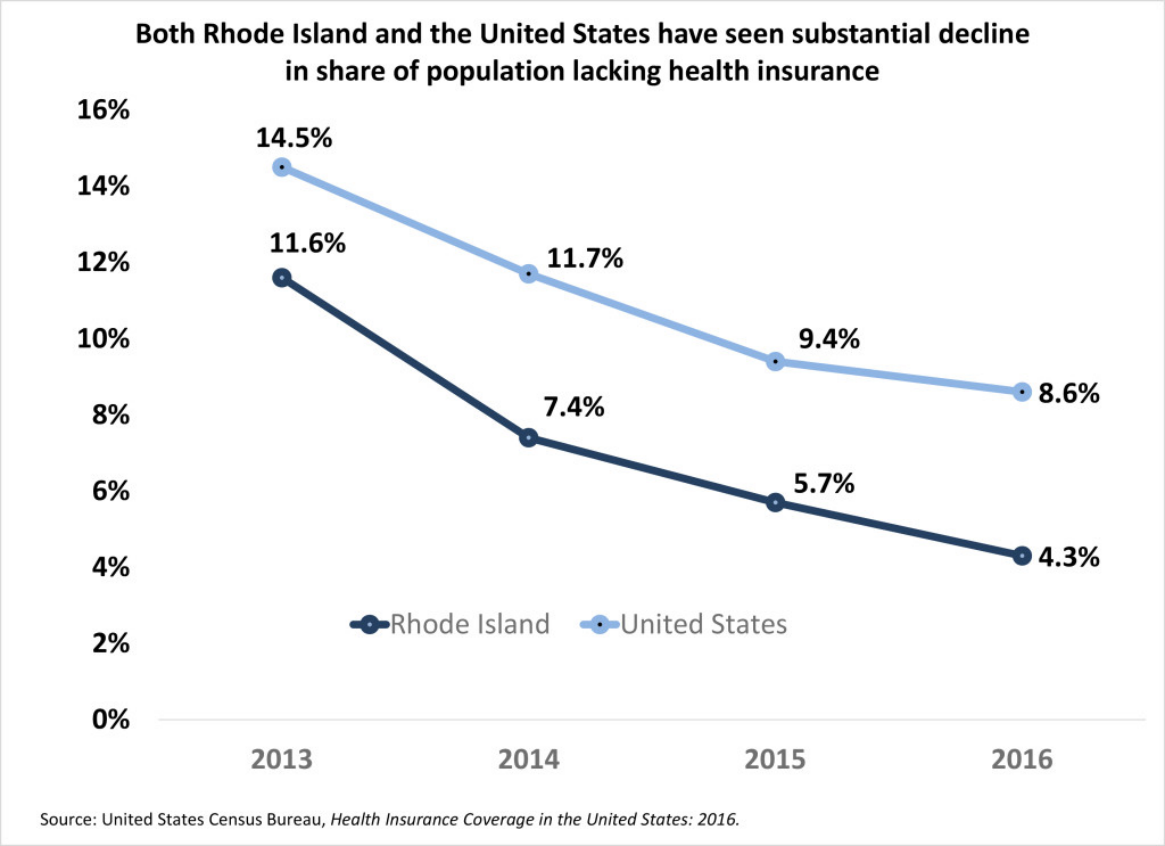
1. Does the Steering Committee believe that rebates are substantive enough that they should be used to adjust pharmacy spend in the total health care spending calculation?
2. If so, should they be used to adjust total medical expense, or administrative expense ("net cost of health insurance")?

How to Capture Health Care "Spending" by Individuals Without Insurance

During the 9/17 meeting we talked about the challenges of accounting for uninsured costs incurred by providers.

Costs incurred by providers to treat those uninsured do not represent *spending* in the state or by payers. Also, the costs are reflected to some degree in payer rates.

The Steering Committee asked that we investigate what the costs may be and what the trends are in the number of individuals who are uninsured.



How to Capture Health Care "Spending" by Individuals Without Insurance

A study on the costs of uninsured in RI was published in 2010. It calculated the per-capita costs of uninsured using 2005 data, trended forward to 2010.

Given that the ACA decreased the number of uninsured, the per-capita costs calculated in 2005, even trended forward to today's dollars, do not account for the risk and demographic profile of the uninsured today. Therefore we did not use the data to estimate today's costs.

We did not find any other reasonable source for the purpose of sharing a cost figure for today's meeting.

How to Capture Health Care "Spending" by Individuals Without Insurance

How might a proxy for provider costs associated with those uninsured be created?

- FQHCs might be able to help develop a proxy with information on the types of services uninsured patients seek.
- Hospitals might be able to help develop a proxy through their published charity care calculations.

If a proxy for costs associated with services for the uninsured were to be created, it could only be attributed to total state spending.

➢Given all of the above considerations, does the Steering Committee wish to task Steering Committee staff to develop a methodology to approximate the costs of uninsured?

Spending Growth Target vis-à-vis OHIC's Hospital Rate and ACO Budget Caps

As many of you know, OHIC implemented hospital rate and ACO budget growth caps in its Affordability Standards. These caps are intended to keep commercial hospital rates and ACO budgets from growing no faster than inflation (as measured by CPI-U Less Food and Energy).

A statewide spending growth *target* on total health care spending is not inconsistent or in conflict with OHIC's regulatory rate *caps*, and each can use a different economic index reference because...

- OHIC's rate caps focus on elements of health care spending – hospital rates and ACO budgets. The spending growth target focuses on **total** health care spending.
- OHIC's rate caps focus on commercial insurers and fully insured populations. The spending growth target focuses on all payers, including Medicare, Medicaid and self-funded employers.
- OHIC's rate caps can help commercial insurers meet the statewide spending growth target as hospital rates and ACO budgets are significant sources of spending.

Cost Growth Target Index: Co-Chair Recommendation

Recommendation: Potential Gross State Product (PGSP) is the index most closely aligned with the goal of this work – which is 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.

➢ *Median income growth* tells an important story, but we are trying to tackle all costs – not just premiums and other expenses paid by individuals.

➢ *CPI-U less food and energy* focuses on changes in price only, and health care spending growth is a result of changes in both price and service utilization

Finally, there is value in being consistent with the approach that Massachusetts and Delaware have taken. Doing so will help put Rhode Island's future performance in context.

Cost Growth Target Performance Assessment: Data Sources

Data Sources

In order to assess state, insurer and provider performance relative to the annual cost growth target, data will have to be gathered and analyzed.

The Steering Committee has previously recommended that total health care spending be calculated using the following types of spending:

- Claims-based spending
- Non-claims-based spending

We will now consider options for obtaining these data.

Which Entities Will Produce Total Health Care Spending Data?

As you review the content on the following slides, please consider these questions:

1. Which entities have data on total health care spending?
2. What is the relative effort required for each entity to produce data on total health care spending?
3. What are the pros and cons associated with the options?

Data Needs and Potential Data Sources

	HealthFacts (APCD)	OHIC	Payers*
Claims-based payment: *fully insured*	Yes	Yes – but only at aggregate insurer level	Yes (No Part D for Medicare)
Claims-based payment: *self-insured*	Partial	Partial	Yes
Non-claims-based payment	No	Yes – but only at aggregate insurer level & for fully insured	Yes
Net cost of health insurance**	No	Yes	Yes
Pharmacy rebate	No	Yes	Yes

* Inclusive of health plans, Medicaid (FFS) and Medicare (FFS).
** Inclusive of insurer administrative expense, insurer profit/reserve contribution, and patient cost sharing.

Massachusetts' Approach

The Center for Health Information and Analysis (CHIA) collects data based on its statutory authority from multiple sources that are used to calculate performance against the cost growth target.

Commercially-Insured Expenditures

- 10 largest commercial payers in Massachusetts
- Commercial payers offering MassHealth (Medicaid)
- Commonwealth Care MCO plans

Publicly-Insured Expenditures

- CMS (Medicare)
- MassHealth FFS and MassHealth MCOs
- Health Safety Net
- Medical Security Program
- Veterans Affairs

Massachusetts' Approach

Each payer provides CHIA with spending summarized at the provider group, zip code and payer product level with up to four months of claims runout, along with claims completion and settlement estimates.

- Legislation requires CHIA to report on the state's progress toward the cost growth target on September 1 of each year. This led CHIA to not wait for the close of the year, or permit a longer claims run-out time period (often, 6 months).

Annually, CHIA updates its prior year's performance calculation with up to 16 months of claims runout and settlements.

Massachusetts' Approach (Cont'd)

Massachusetts has a functioning APCD, so why did it choose to have payers report the data?

1. MA had a pre-existing total medical expense reporting framework.
2. Relying on the APCD would require supplemental reporting (for payers and expenditures not in the APCD).
3. It leveraged existing payer-provider relationships to explain the metrics to providers.
4. Massachusetts found it to be administratively simpler for payers to report than using the APCD, and reduced the need for the state to validate APCD calculations.

Delaware's Proposed Approach

The Delaware Secretary of Health and Social Services has recommended that the state collect payer data in similar fashion to Massachusetts.

- Delaware does not currently have a fully functioning APCD.

She recommended that Delaware's insurers pre-analyze the data so that the state's Health Care Commission is not receiving raw claims files.

- Delaware does not have a CHIA-like health data agency, and so sought to minimize the resources required to calculate performance against its cost growth target.
- Still, the Health Care Commission will need to work with external sources to help analyze the data and report performance.

In the future, Delaware has a desire to use its to-be-completed APCD to the extent feasible, but has not yet developed a strategic plan to do so.

Weighing the Data Source Options: Making HealthFacts the Data Source

Pros	Cons
The data is already being collected and has been used for at least some reporting.	To calculate accurate total expenditures, it will be necessary to confirm the accuracy of the state-administered spending aggregation methodology with the payers. In order to calculate accurate PMPM expenditures, it will also be necessary to confirm the accuracy of enrollment counts.
The granularity of claims data allows for multiple analyses of the drivers of increasing health care costs, including the ability to answer specific questions in the future.	Using an APCD to accurately group providers into provider organizations tends to be difficult. The APCD may also not include helpful information about plan types (benefit design).
It is possible to apply a common risk adjustment tool to claims data from different insurers, allowing for risk-adjusted analyses across payers.	Applying risk adjustment across multiple payer claims is a non-trivial task and will require resources and effective oversight.

Weighing the Data Source Options: Making HealthFacts the Data Source

Pros	Cons
The state can define methodological choices, such as calculating claims run-out (completion percentages).	Expenditures included in HealthFacts omit non-claims payments, such as ACO risk settlements, ACO investments, pay-for-performance payments and capitation.
	HealthFacts omits certain payers: some self-insured employer plans, insurance companies with fewer than 3,000 members, and (possibly) FEHBP plans.
	EOHHS would be wholly responsible for the accuracy of APCD-based total cost of care calculations, and may face requests from any named payers and providers to be completely transparent about their methodology and calculations. This may lead to complex back-and-forth discussions with stakeholders.

Weighing the Data Source Options: HealthFacts, OHIC and Payers

Using HealthFacts as a data source offers substantive benefits and a return on a large infrastructure investment, but also has significant limitations.

OHIC and/or public and private payer data present an alternative, but have limitations as well.

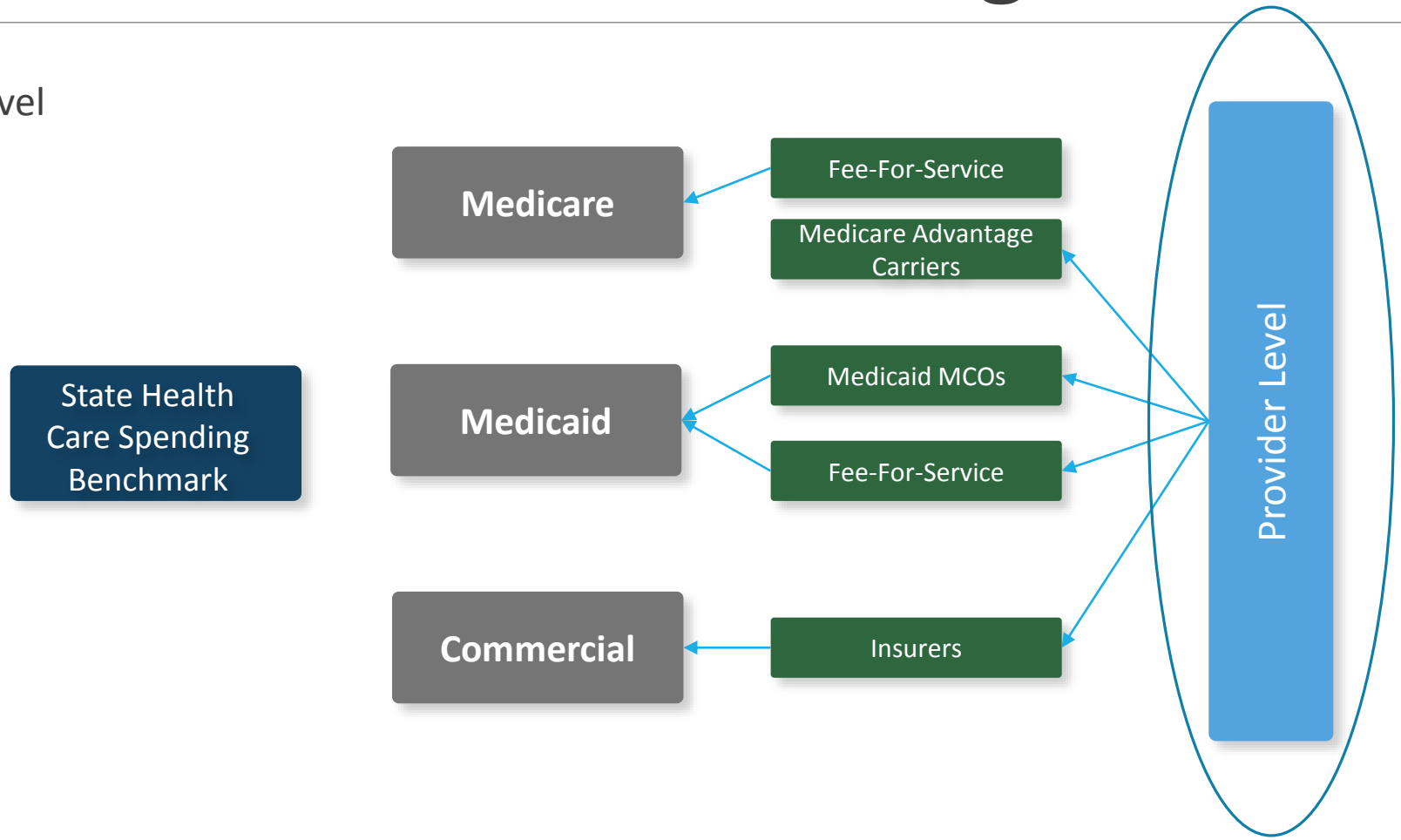
- OHIC data is incomplete - partial non-claims-based data and net cost of health insurance; only available at aggregate insurer level; not for FFS Medicare or Medicaid
- Insurer data generation has significant associated insurer cost - cost estimates from Mass. insurers for CHIA reporting: $10K, $50K and $200K annually

How does the Steering Committee assess these data source options?

Assessing Performance at the Provider Level: Patient Attribution and Risk Adjustment

Target Performance Assessment: Whose Performance is Being Assessed

Provider level



Provider Level Performance Measurement

During the 9/24 meeting, we discussed…..

1. What types of providers should be included?

Today we will continue by discussing…..

2. How will patients be attributed to those providers?
3. How many attributed patients must a provider have for its health care spending growth rate to be calculated?
4. To which types of providers should patients be attributed?
5. Does the difference in clinical risk across providers or do changes in clinical risk attributed to one provider get adjusted, and if so, how?

Patient Attribution: Why It's Important

Performance against the target needs to be reported on a *per capita* basis because doing so takes into account the three driving factors of health care spending growth: price, volume and service mix.

To report on a per capita basis, the spending of patients/members needs to be attributed to one provider.

The Steering Committee's decision on data source will heavily influence this recommendation.

Let's now consider how patients could be attributed to any given provider.

Patient Attribution: Two Approaches

Method	Pros	Cons
1. Patients are attributed using a common patient attribution methodology, where payers work together to agree upon a methodology and apply it to this process.	Increases comparability across insurers.	Could add a layer of complexity to the process (if payers report data vs. using the OHIC or the APCD as the data source.
2. Patients are attributed using each payer's own attribution methodology employed with their value-based payment contracts or for other purposes.	Make reporting easier for insurers (if payers report data vs. using OHIC or the APCD as the data source).	The variation in methodology might produce inconsistent results.

→CTC-RI reports that today RI insurers use attribution methodologies that are similar but not exactly the same.

Massachusetts' Approach to Patient Attribution

Massachusetts has developed a four-step patient attribution process (*remember, Mass has insurers report performance rather than use its APCD*).

1. Insurers first attribute spending by Massachusetts members who are required to select a primary care provider by plan design.
2. Then, by members who were attributed during the reporting year to a PCP, pursuant to a contract between the payer and provider for financial or quality performance.
3. Next, by members attributed to a PCP by the payer's own attribution methodology.
4. Finally, by members not attributable to a PCP are reported to CHIA at the insurer and state level (and not at the provider level).

Note: MA law requires that "to the maximum extent possible [insurers] shall attribute every member to a primary care provider" (hence Step 4.)

Patient Attribution: Recommendation

Does the Steering Committee recommend a single attribution methodology, or deferring to each payer's existing methodology?

How Many Attributed Patients Must a Provider Have for its Spending Growth Rate to be Calculated?

As described during the 9/24 meeting, Massachusetts calculates target performance for providers with 36,000 member months (**3,000 lives**) *at the individual payer level*.

To ensure statistically robust results and to reduce resources required for analytic activity, Steering Committee staff propose setting the threshold at 120,000 member months (**10,000 lives**) – *at the individual payer and aggregate level by line of business (commercial, Medicare, Medicaid)*.

Pros	**Cons**
1. Will reduce the effects of random variation	1. Will limit # of providers
2. Will reduce resources needed for analysis.	2. Payers have risk contracts <10K lives

Why 10K lives?

- Consistent with OHIC threshold for Minimum Downside Risk requirement.
- Could increase threshold to 20K for commercial and Medicaid for increase statistical confidence, but would lose a number of provider/payer dyads if doing so.

Patient Attribution: What Types of Providers Should be Included?

Provider Type	Pros	Cons
Hospitals and Health Systems	• Health systems are one of the principle organizers of care in Rhode Island	• Some small hospitals will have small attribution numbers • Health systems may operate as ACOs with independent physician networks
Medical groups with primary care, including FQHCs	• Medical groups are one of the principle organizers of care in Rhode Island	• Only the largest practices would meet minimum volume thresholds

Patient Attribution: What Types of Providers Should be Included?

Provider Type	Pros	Cons
IPAs	• There is a large RI IPA	• None identified
ACOs	• Patients are already attributed to ACOs for the purposes of their contracts • There is significant ACO contracting activity in RI	• ACO networks can vary by payer contract, making it difficult to determine which network to use when determining performance

Risk Adjustment

The composition of a payer's or provider's population – including it's clinical risk profile - may change over the course of the year.

Such changes will have an impact on spending growth, e.g., a population that is sicker than a year prior should be expected to have higher health care spending.

For this reason, assessment of payer and provider performance relative to the target should be adjusted for population clinical risk.

Such an adjustment is not required at the state level since the state population is expected to be fairly stable over the course of one year.

Risk Adjustment Approach

If providers are going to have patients and their associated expense attributed to them, differences in clinical risk should be considered.

There are two ways in which risk adjustment might be done.

Method	Pros	Cons
1. Each insurer uses its own risk adjuster (if using payer-reported data)	• Administratively less complex	• Provider spending growth rates can't be compared against each other as easily since how clinical risk is adjusted for is different
2. A common risk adjuster is used	• There are publicly available risk adjusters that could be used (HCCs)	• Administratively more complex - if using payer-reported data

Massachusetts: Each Insurer Uses Its Own Risk Adjuster

	Risk Adjustment Tool and Version		
Payer	**2014 Final**	**2015 Final**	**2016 Preliminary**
Aetna Inc.	Ingenix ERG Retrospective v8.2.116	Ingenix ERG Retrospective v8.2.130	Ingenix ERG Retrospective v8.2.130
Blue Cross Blue Shield of Massachusetts	DxCG Version 4.2	DxCG Version 4.2	DxCG Version 4.2
BMC HealthNet Plan	DxCG 4.3.1	DxCG 4.3.1	DxCG 4.3.1
Celticare Health Plan of Massachusetts	Optum Impact Pro V7 & V8	Optum Impact Pro V7 & V8	Optum Impact Pro V7 & V8
Cigna Health and Life Ins. Co. (EAST)**	ERG INGENIX 7.5	ERG INGENIX 7.5 & 8.3	ERG INGENIX 8.3
Cigna Health and Life Insurance Company (CHLIC)	MedAssets Refined DRG Grouper RDRG r24	MedAssets Refined DRG Grouper RDRG r24	MedAssets Refined DRG Grouper RDRG r24
Fallon Health	Optum IIRP v4.1	Optum IIRP v4.1	Optum IIRP v4.1
Harvard Pilgrim Health Care	DxCG 4.1 model 18	DxCG 4.1 model 18	DxCG 4.1 model 18
Health New England	MARA 2.2.4.0	MARA 3.8	MARA 3.8
Health Plans Inc. (Harvard Pilgraim Health Care)	DxCG 5.0 model 18	DxCG 5.0 model 18	DxCG 5.0 model 18
Minuteman Health, Inc.	Federal HCC Risk Adjustment 2015	Federal HCC Risk Adjustment 2015	Federal HCC Risk Adjustment 2015
Neighborhood Health Plan	DxCG 5.1	DxCG 5.1	DxCG 5.1
Tufts Health Public Plans, Inc. (Network Health LLC)	DxCG Intelligence 4 GUI 4.2.0	DxCG Intelligence 4 GUI 4.2.0	DxCG Intelligence 4 GUI 4.2.0
Tufts Health Plan***	DxCG 5.0	DxCG 5.0	DxCG 5.0
Tufts Medicare Advantage	CMS Monthly Membership Report	CMS Monthly Membership Report	CMS Monthly Membership Report
UniCare Life and Health Insurance Company	DxCG 4.1.0	DxCG 4.1.0	DxCG 4.1.0
UnitedHealthcare	Symmetry Episode Risk Grouper 8.3	Symmetry Episode Risk Grouper 8.3	Symmetry Episode Risk Grouper 8.3
United Medicare Advantage	2007 CMS-HCC & CMS Monthly Membership Report	2007 CMS-HCC & CMS Monthly Membership Report	2007 CMS-HCC & CMS Monthly Membership Report

Risk Adjustment: Recommendation

Does the Steering Committee recommend a single risk adjustment methodology, or deferring to each payer's existing methodology?

Cost Growth Target Timeline

Process Questions: Target Setting

- We set out with the intention of setting a cost growth target for 2019.

- Once the target is set for 2019, we have three questions:

1. Should the target cover one or more years? If more, how many?
2. If the target is multi-year, should it change over time or be fixed?
3. Should there be a periodic review of the target setting methodology? If so, what should be its scope, and how often should it be performed?

MA and DE Cost Growth Target Timing

Massachusetts' Approach

Year	Target
2013–2017	PGSP (3.6%)
2018–2022	PGSP – 0.5%
2023+	PGSP or another value, at the discretion of the Health Policy Commission

Delaware's Recommended Approach

Year	Target
2019-2023	PGSP calculated as of 2018*
2023+	Health Care Commission can change methodology

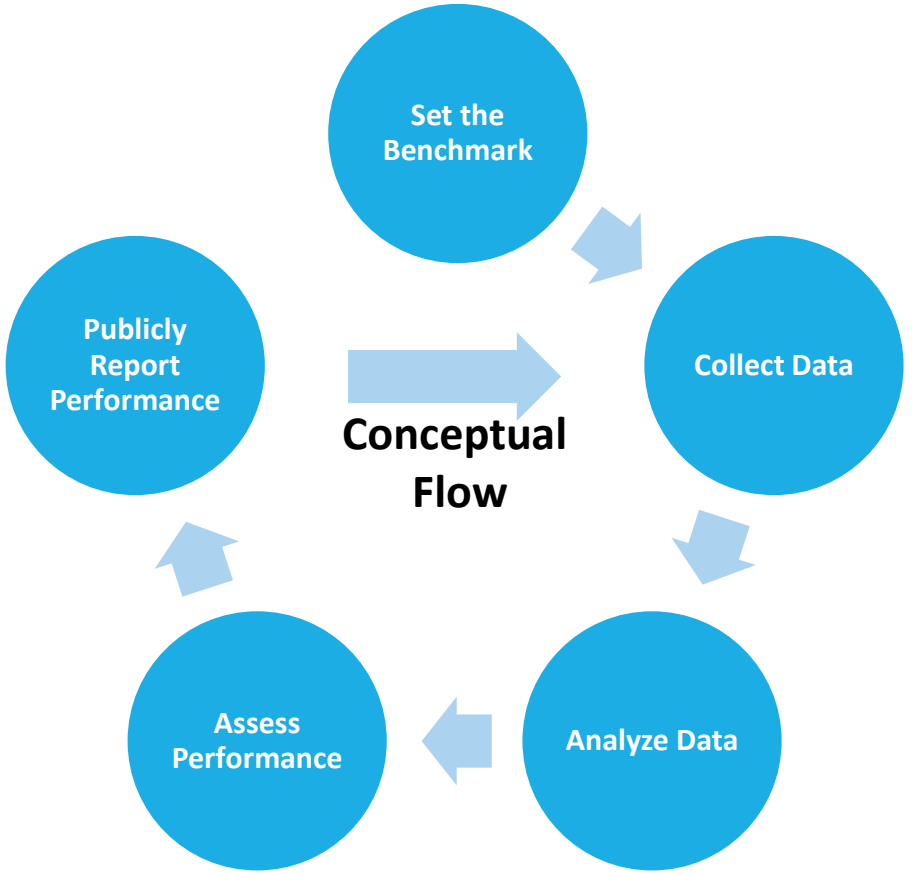
*Annually the components of PGSP will be reviewed to determine whether they changed significantly enough to warrant a change in the state's cost growth target.

Target Timeline: Recommendation

1. Should the target cover one or more years? If more, how many?
2. If the target is multi-year, should it change over time or be fixed?
3. Should there be a periodic review of the target setting methodology? If so, what should be its scope, and how often should it be performed?

Timeline for Implementing Target Policy Recommendations

What is the timeline for implementing the target in 2019 and ongoing?



Estimated Cost Target Timeline

- **January 1**: Year 1 begins
- **November 1**: Year 2 cost target announced *(should it be different than 2019)*
- **December 31**: Year 1 ends

- **January 1**: Year 2 begins
- **August 1**: Data from Year 1 (2019) is received and performance review begins
- **October 1**: Year 1 performance announced
- **November 1**: Year 3 cost target announced *(should it be different than 2020)*
- **December 31**: Year 2 ends

- **January 1**: Year 3 begins
- **December 31**: Year 3 ends

Interest in Establishing Quality Targets

- During the 9/17 Steering Committee meeting, some Steering Committee members expressed concern about discussing spending in a vacuum and wanted to discuss quality targets too.

- Since the discussion was not pertinent to the development of the cost growth target, the Steering Committee decided to revisit the topic at a later date.

- **Is the Steering Committee interested in recommending the establishment of quality targets?**
  - If there is interest, we can allocate some time during the 11/5 meeting to begin this discussion.

Public Comment Period

Wrap-Up and Next Meetings

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

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
2019 schedule	*coming soon*