Network for Regional Healthcare Improvement

R.E.A.L. SOLUTIONS

RESULTS AND EVIDENCE FOR ACTION-BASED LEARNING

R.E.A.L Solutions *(Results and Evidence for Action-Based Learning)*

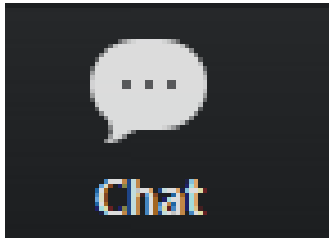
Healthcare Cost Transparency Reporting- Cost Growth Targets

September 29, 2020
3:00 – 4:00 PM

A Few Reminders

Please mute / unmute when not speaking

Please share your video if you are able!



When you want to speak up, please give a little wave or chat that you'd like to speak, and the facilitator will call on you

Please chat in your name and organization now

Today's agenda

- Overview of objectives for REAL Solutions
- Featured Presentation: *Cost Growth Targets: What Are They and How Do We Define Them?*
- Case presentation
- Open Discussion/Recommendations for Case presentation
- Closing announcements

Objectives

- Increase member connections
- Explore topics of shared member interest
- Provide opportunity for shared learning and problem solving

Today's Speakers

Michael Bailit

President, Bailit Health

www.bailit-health.com

Richard Gibson

Physician Informaticist, Comagine Health

Previously he was a family physician, emergency physician, chief medical information officer, and chief information officer at integrated health systems in Portland, Oregon.

Cost Growth Targets: What Are They and How to Define Them

Michael Bailit
President
Bailit Health Purchasing, LLC

Agenda

1. The need for cost growth targets
2. Design questions to define a cost growth target
3. Establishing a target during COVID-19
4. The role of an APCD

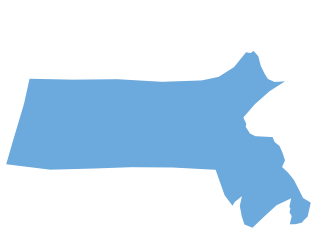
The need for cost growth targets

What is a cost growth target?

A health care cost growth target is a per annum rate-of-growth benchmark for health care spending in the state.

- States sometimes interchangeably use the terms “target” and “benchmark”, as well as “cost” and “spending.”

Six states either have existing cost growth target programs or are in the process of developing one.



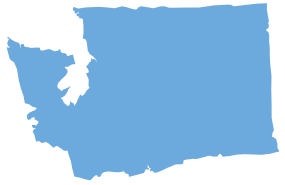
Massachusetts (2013)

Delaware (2019)

Rhode Island (2019)

Oregon (2021)

Connecticut (2021)



Washington (2023)

Why are states pursuing cost growth targets?

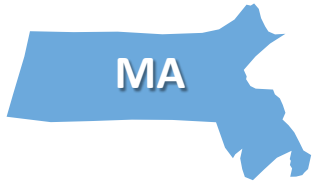
Because health care is unaffordable for states and consumers!

National Trends

Per Capita Cost Growth 2017-2018: 4.0%

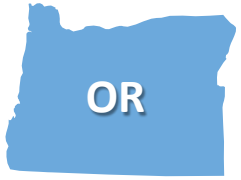
GDP Growth Q4 2018: 2.6%

Nominal Wage Growth Dec 2018: 3.38%



State-purchased health care rose 40% over 12 years; all other services reduced 17% on average

Insurance rate filings in the large and small group markets outpaced annual wage growth



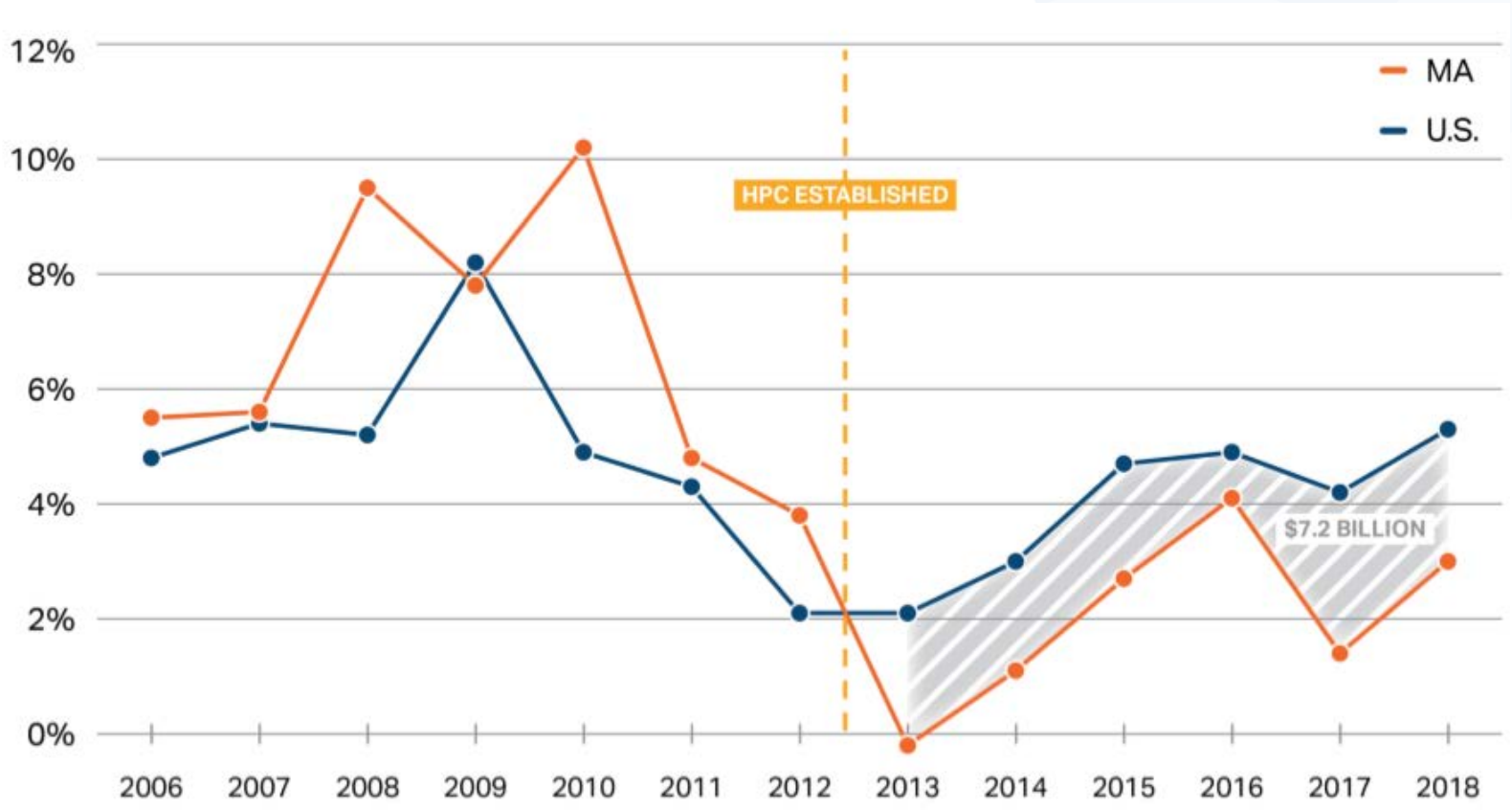
Premiums equated to 29% of a family's total income

Employer-sponsored insurance premiums have grown 2.5x faster than personal income since 2000

What are other states' experiences with cost growth targets?

In Massachusetts, from 2012 to 2018, annual health care spending growth averaged 3.38%, below the state benchmark.

Commercial spending growth in MA has been below the national rate every year since 2013.



HPC

Notes: U.S. data includes Massachusetts.
Sources: CMS National Healthcare Expenditure Accounts, Personal Health Care Expenditures Data (U.S. 2014-2018) ; CMS State Healthcare Expenditure Accounts (U.S. 2000-2014 and MA 2000-2014); CHIA Annual Report THCE Databooks (MA 2014-2018).

Design questions to define a cost growth target

1. What types of spending should be measured?

Cost growth targets typically focus on total health care expenditures (THCE), which has three components:

a. All **medical expenses, including non-claims payments**, paid to providers by private and public payers, including Medicare and Medicaid
b. All **patient cost-sharing** amounts (e.g., deductibles and copayments)
c. The **net cost of private health insurance** (e.g., administrative expenses and operating margins for commercial payers)

Prescription drug rebates, granted to PBMs and insurers from drug manufacturers, are often substantial and therefore collected with THCE data. THCE is typically reported net of rebates.

THCE is a per capita measure.

2. Whose “total health care expenditures” are being measured?

In order to capture THCE, one must determine:

a. the population whose health care expenditures should be measured and
b. the sources of insurance coverage for that population.

Data access often plays a role in which coverage groups can be included. The following slides, however, discusses the above topics without consideration of how to obtain the needed data.

3. What is the value of the cost growth target?

States have typically selected a value for the cost growth target that can (a) provide a stable and predictable target and (b) rely on independent, objective data sources with transparent calculations.

There are several decisions one needs to make to set the value of the target, including:

a. which data source to use to set the value,
b. whether to use historical or forecasted data and
c. whether to make any adjustments to the target.

3. Which data source to use

There are four primary options to set the value of the target:

	Annual Gross State Domestic Product	Rate of Personal Income Growth	Rate of Growth in Wages	Inflation, measured by CPI-U
	The total value of goods produced and services provided in a state during a defined time period	Growth in all payments received by residents (e.g., wages, salaries, benefits, pensions)	Growth in compensation received for work as an employee or contractor	Prices paid by consumers for a "market basket" of goods (e.g., food, clothing, transport)
	Implies that health care should not grow faster than the economy	Implies that health care should not grow faster than personal income growth	Implies that health care should not grow faster than residents' "take-home pay"	Implies that health care spending should not grow faster than the rise in consumer prices

3b. Historical or forecasted data

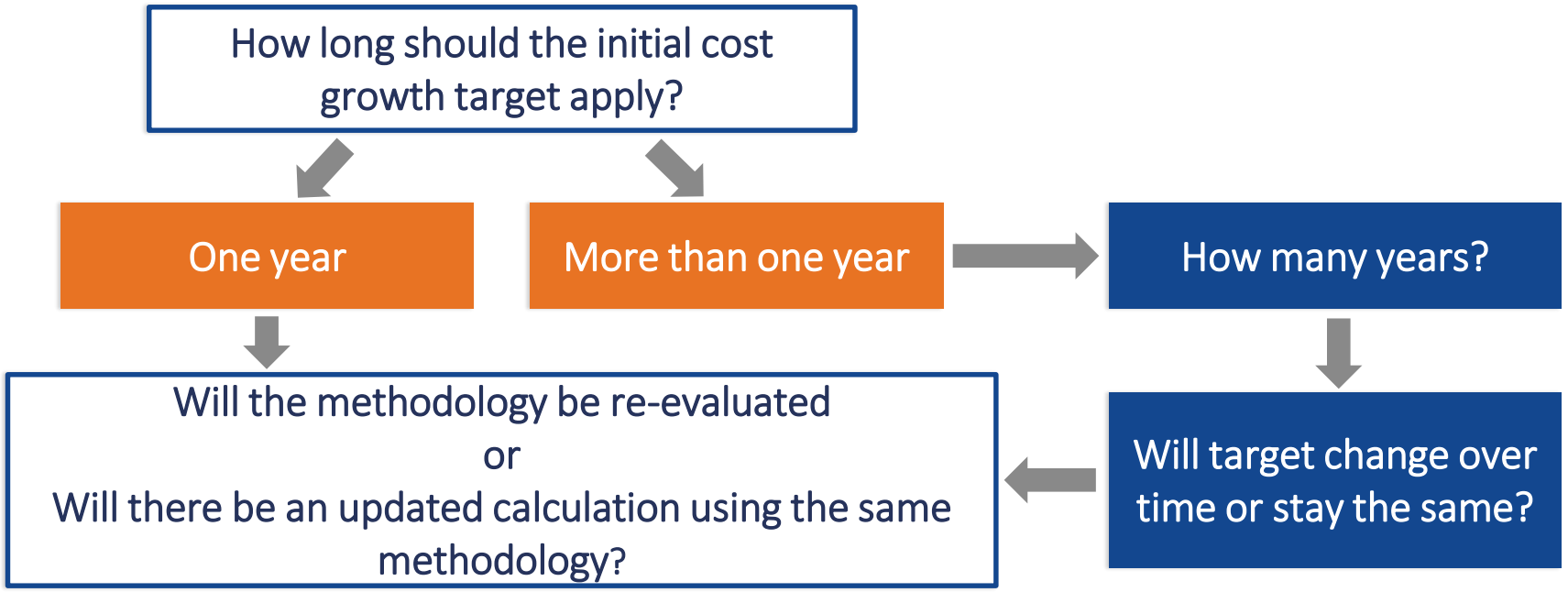
There are two ways to calculate an economic indicator:

- based on **historical experience**, which reflects to varying degrees the volatility of year-over-year changes, or
- based on a **forecasted projection**, which are designed to predict stable future figures.

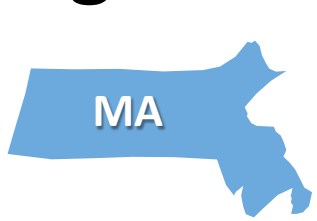
	Advantages	Disadvantages
Historical	• Easy to calculate. • Reflects actual experience, which is unstable.	• Highly variable, reflecting economic booms and busts. • Unclear rationale for which time period to choose.
Forecasted	• Smooths out historical variability and provides more stability and predictability.	• Forecasts are predictions and may be incorrect. • Some forecast methodologies are opaque.

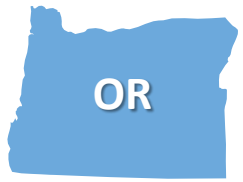
3c. Adjusting the target (1 of 2)

States set annual cost growth targets for anywhere between four to ten years in the future. However, there are situations in which states may want to adjust the target value and/or methodology.



Putting it all together: what have other states done?





Indicator Utilized	PGSP (with modifiers in select years)	PGSP (with modifiers in select years)	PGSP	Informed by historical GSP and median wage	PGSP and median income (with modifiers in select years)	TBD
Adjustment Mechanism	Could adjust after the first five years	Review annually for any "material" change in forecast	Revisit if there are "highly significant" economic changes	2026-2030 values to be reassessed in 2024	Revisit if there is a sharp rise in inflation	TBD
2021 Target Value	3.1% (PGSP -0.5%)	3.25% (PGSP +0.25%)	3.2%	3.4%	3.4% (20% PGSP/80% med. income +0.3%)	TBD

4. At what level should performance be assessed? (1 of 2)

Performance can be assessed at four levels.

Statewide	Statewide		
Market Level	Medicare	Medicaid	Commercial
Insurer Level	FFS; Medicare Advantage	FFS; Managed Care	Insurers (fully insured and self-insured)
Provider Level	Large Providers with Attributed Members	Small Providers with Attributed Members (not separately identified)	Spending for Unattributed Members

4. At what level should performance be assessed? (2 of 2)

In order to publish health care spending growth by provider, there are four questions that a state must address:

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

Establishing a target during COVID-19

COVID-19 impact on health care spending

While it is not yet certain how COVID-19 will impact spending, preliminary national and state data offer clues:

- **Telehealth visits** have increased dramatically
- Despite the shift to telehealth, **significant drops in health care service utilization** occurred and continue for some specialties, e.g. pediatrics
- **Expensive COVID-related inpatient admissions** have not offset utilization drops **enough to prevent significant hospital revenue losses**
- **Pent-up demand may be released** after relaxing of social distancing policies
- **Non-traditional health care spending** has occurred to support providers

COVID-19 potential impact on cost growth targets

Should the experience of COVID-19 be considered when setting the cost growth target value?

- The target's intended use is to establish a stable, multi-year expectation for spending growth
- Unusual events – including a pandemic – may cause occasional and time-limited fluctuations in spending
- Providers and plans would not be penalized for increased spending associated with COVID-19

None of the states with cost growth targets have suspended them, or even changed the values, due COVID-19

The role of an APCD

What is a data use strategy?

In order to make progress in reducing cost growth to meet the cost growth target, stakeholders must have information on where costs are **high**, **growing rapidly** and **variable**.

States are leveraging a **data use strategy**, or a plan to purposefully leverage state data - primarily the APCD - in order to achieve the aims set forth by the target.

- Analyses often focus on cost drivers (what contributed to cost growth), cost drivers (what is causing costs to be so high) and costs in the context of population demographics.
- They can also help identify any unintended consequences that arise as a result of the target (e.g., underutilization of needed services, increase of consumer out-of-pocket spending).

Opportunities for NHRI members

- Most states lack experience translating APCD data into intelligence that will allow targeting of efforts to address cost drivers.
- Some states will seek assistance with performing this function, or in taking state analyses steps further to support improvement activity.

Questions?

Resources

State Cost Growth Targets

- Connecticut: https://portal.ct.gov/OHS/Content/Cost-Growth-Benchmark
- Delaware: https://dhss.delaware.gov/dhcc/global.html
- Massachusetts: https://www.mass.gov/info-details/health-care-cost-growth-benchmark
  - CHIA Annual Reports: https://www.chiamass.gov/annual-report/
  - HPC Annual Process for Monitoring Spending Growth: https://www.mass.gov/service-details/hpc-datapoints-issue-10-health-care-cost-growth-benchmark
- Oregon: https://www.oregon.gov/oha/HPA/HP/Pages/Sustainable-Health-Care-Cost-Growth-Target.aspx
- Rhode Island: http://www.ohic.ri.gov/ohic-reformandpolicy-costtrends.php

Other Resources

- Implementing a Statewide Healthcare Cost Benchmark - Manatt: https://www.manatt.com/insights/white-papers/2019/blueprint-for-building-an-effective-statewide-heal
- Health Care Cost Growth Benchmarks in 5 States – *JAMA Forum* https://jamanetwork.com/channels/health-forum/fullarticle/2767017
- Cross-Agency Strategies to Curb Health Care Costs: Leveraging State Purchasing Power – NASHP: https://nashp.org/wp-content/uploads/2019/04/States-Leverage-Purchasing-Power.pdf
- Overview of States' Health Care Cost-Growth Benchmark Programs – NASHP: https://www.nashp.org/how-states-use-cost-growth-benchmark-programs-to-contain-health-care-costs/

Today's Case

Richard Gibson, MD, PhD
Physician Informaticist
Comagine Health
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Motivation for a Cost Growth Target in Oregon

- Total health care premiums are equal to 29% of Oregonian's income
- Oregon deductibles are the highest of all the neighboring states and the fourth highest in the country
- Oregon Health Plan (Medicaid) and State employee health plans cover 1.3 million Oregonians, a third of all Oregonians, already limited to 3.4% increase year-over-year
- A cost growth target is not a disparity reducer – low cost providers get stuck at a low rate and high cost providers stay high
- For 2013-2017, growth rate averaged 6.5% year-over-year

Which payer types are included? Decreasing value of greater effort

54% of Oregonians: Commercial (both fully and self-insured)

23% Medicaid

15% Medicare fee-for-service and Medicare Advantage

--(92% Subtotal: straightforward to obtain the above data)----------

1% VA

2% Indian Health Service

1.5% Federal employees & Tricare

0.5% Corrections

6% Uninsured: payers don’t have these data

What indicator should the cost growth target be based on?

- Oregon committee chose to base target on:
  - A blend of historical Oregon Gross State Product and Oregon Median Wage growth
  - Consideration of the previously established 3.4% cap on Oregon Medicaid and Oregon state employees health plans' expenditure
- Target: 3.4% growth 2021-2025
- Target: 3.0% growth 2026-2030 (will revisit this decision in 2024)
- Each payer will perform their own risk adjustment

How should patients be attributed to primary care providers?

- Single algorithm for entire state?
- Or let each payer make up their own method? Oregon chose this (so far)
- Can obstetrician-gynecologists be primary care providers (PCPs)? (Oregon choosing “no”)
- Can oncologists who direct all patient care be PCPs? (Oregon choosing “no”)

How should providers be attributed to medical groups?

- Oregon has chosen to let each payer make up their own method
- The analysis of “accountable provider” will likely involve only the larger medical groups
- After the cost growth target results have been evaluated, APCD data might be brought in to study the cost of rural providers based on geographic clustering

What is the minimum number of attributed patients for a reliable analysis?

- For a provider group
  - With a given payer
    - In a given product type (Commercial, Medicaid, Medicare)
- Oregon considering 3,000 patients as the minimum size for reproducibility
- Oregon still needs to figure out how to hold hospitals and specialists accountable for costs that don't roll up to a primary care group
- Action Plan: Oregon Implementation Committee has considered the idea of increasing the required percentage of value-based payment each year

COVID-19 and 2020 expenditures

- Law requires Oregon to compare the first year cost (2021) with 2020 cost
- Oregon will also present costs for 2019 and 2018 because 2020 is anomalous- the exact method still to be determined
- Also, requiring 2019 and 2018 data will give payers and the State practice calculating per capita cost before the official submission of 2020 data

Desired outcomes for Oregon

- Data that are reproducible and consistent
- A transparent analytical process
- Meaningful outcomes for Oregonians and their own experience with healthcare
- Effectiveness at decreasing cost growth

Guidance seeking

- ACPDs can’t duplicate the annual payer-supplied data but they can provide insights. How can Regional Health Improvement Collaboratives help support cost growth targets and subsequent cost control efforts?
- How do you manage the cost of care for patients not attributed to a PCP?

Discussion

Closing Announcements

NRHI's Executive Leader Forum: Advancing Health Equity Together

Join us for another Executive Leader's Forum on **October 1st** lead by Dr. Gail Christopher to further discuss our collective commitment to health equity. Your organization's voice and leadership is very much wanted as we continue to define our opportunities to impact change and create influence.

Thursday, 10/1 from 12:30 pm-1:30 pm ET, use the Zoom info below:

https://nrhi.zoom.us/j/96668980061?pwd=RnZJbnpVL1NscVVSVXdMNHRENCtuQT09

Phone one-tap: US: +13017158592,,96668980061# or +16465588656,,96668980061#

Meeting URL: https://nrhi.zoom.us/j/96668980061?pwd=RnZJbnpVL1NscVVSVXdMNHRENCtuQT09

Meeting ID: 966 6898 0061

October NRHI Member Virtual Events

PPP Forgiveness Roundtable: Ask the Experts

- **Date|Time**: October 8th | 1 – 2:00 PM (ET)

Network News with Craig Brammer

- **Date|Time**: October 13th| 12 – 12:30 PM (ET)

View from Washington: NRHI Public Policy Briefing with Sirona Strategies

- **Date|Time:** October 21| 2 – 3:00 pm ET

R.E.A.L Solutions: *Applying a Quality Improvement Structure to Build an Integrated Behavioral Health Program*

- **Date|Time:** October 27| 2 – 3:00 pm ET

Integrated Behavioral Health 2.0 - How Primary Care Practices in Rhode Island Deliver Services During a Pandemic

Join us for the next webinar of our series, where we will hear from Care Transformation Collaborative-Rhode Island (CTC-RI). They will review how adult and pediatric primary care practices have created the new normal for integrated behavioral health (IBH); discuss how data comparing pre-COVID to post-COVID for IBH and Social Determinants of Health has impacted decision-making; and analyze how staffing and burnout has impacted Rhode Island primary care practices with IBH.

Date|Time: October 29| 3 – 4 pm ET

Presenters: Nelly Burdette, PsyD and Liz Cantor, PhD - Collaborative-Rhode Island (CTC-RI)

Tell Us Your Feedback

Your feedback is important to us!

Please take a minute to fill out a brief survey on today's meeting. Your feedback helps us to continuously improve the content and your experience in these meetings .

https://www.surveymonkey.com/r/SeptemberRealSolutions

THANK YOU!!!