Working Group for Healthcare Innovation

http://www.governor.ri.gov/initiatives/healthcare/

Spending Cap Subgroup #1

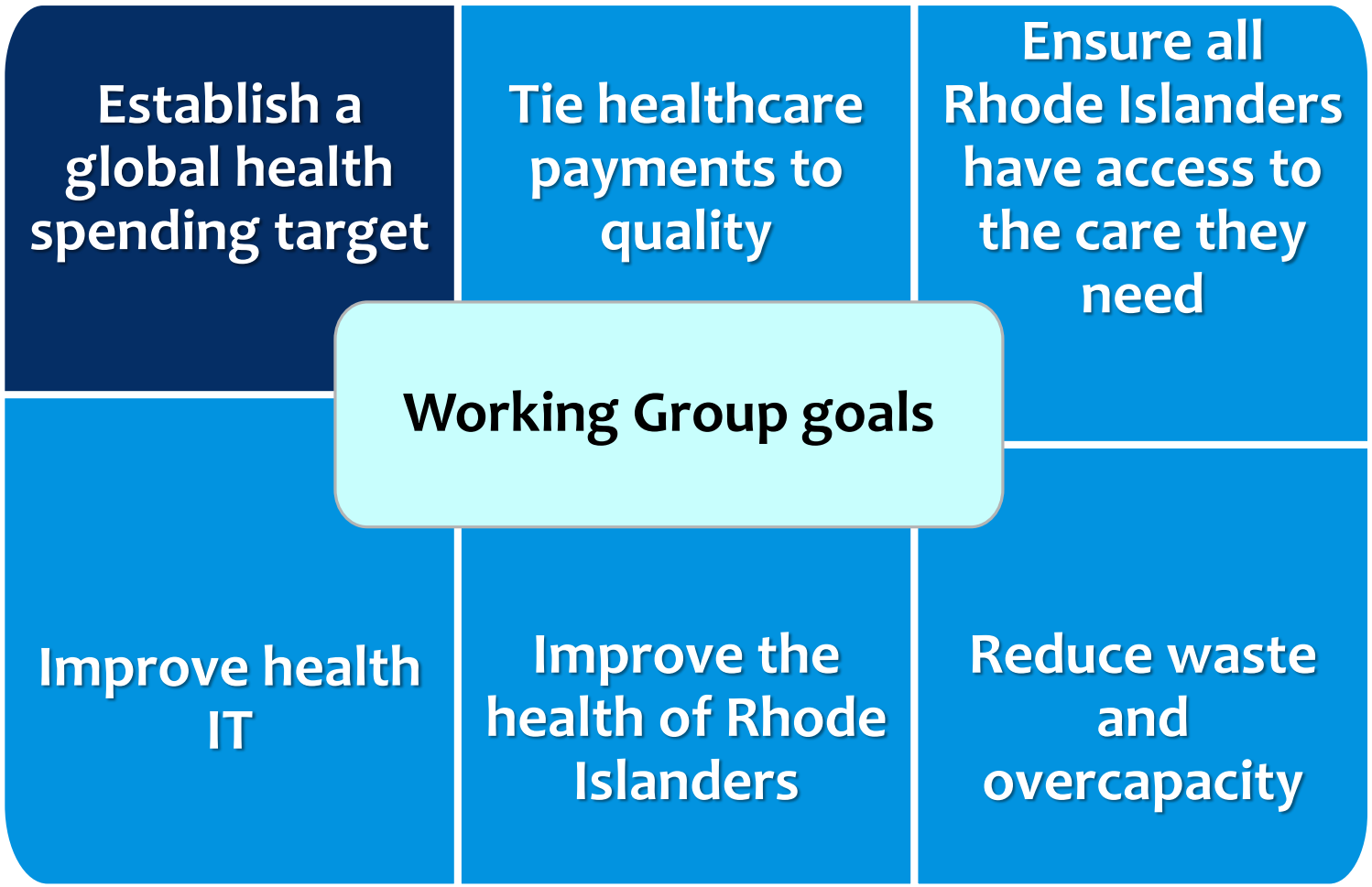
October 13, 2015

Agenda

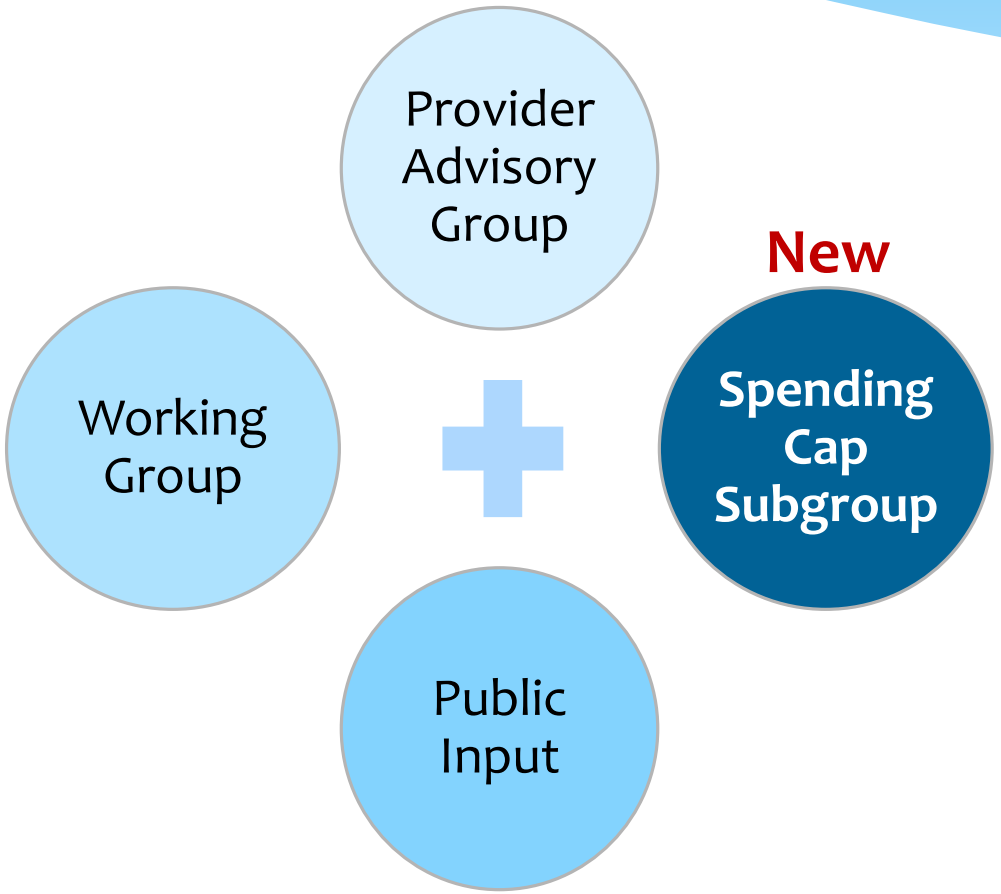
* Introduction & welcome
* Review recent updates from Massachusetts
* Spending cap decision points
* Group discussion
* Public comment

Our goals

Focus for this group



Spending Cap Subgroup



* We wanted more opportunity to get input from the Working Group
* In this group, we'll discuss the specifics of a Spending Cap proposal

Proposed subgroup agenda

* We welcome feedback from the subgroup on what issues are most important for us to cover
  * **October 13:** Spending cap decision points
  * **October 27:** Enforcement mechanisms
  * **November 10:** Review early spending cap proposal
  * **November 17:** Other key health reform goals (payment reform, price transparency, health information technology)

Review: Update from Massachusetts

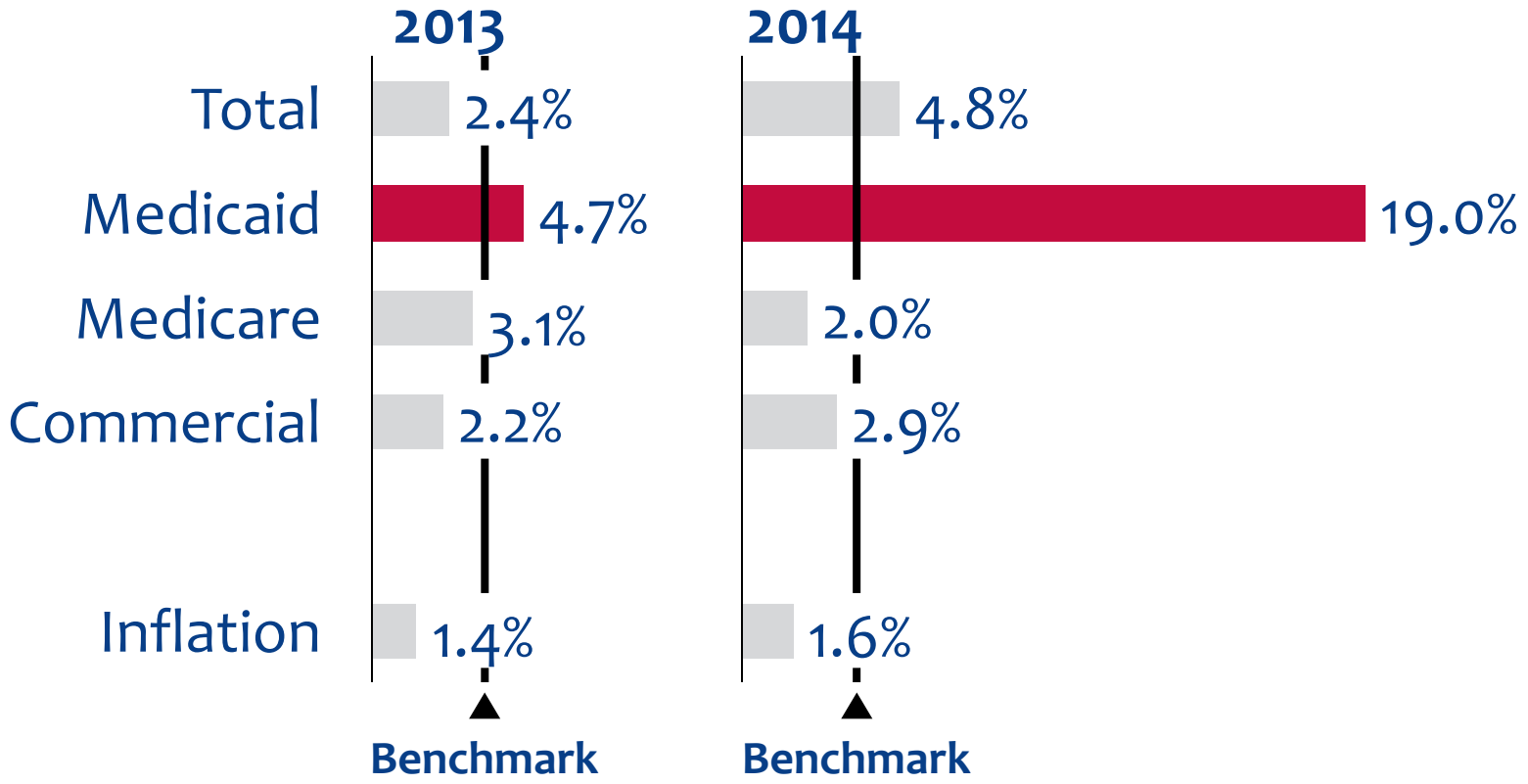
In a setback for Mass., health care costs spike in state

4.8% rise tied to plan for poor, drug prices

* Massachusetts was the first state in the country to implement a statewide health spending cap of 3.6%, which began in 2013
* In 2014, Massachusetts health spending grew by 4.8%, driven by a **19%** rise in Medicaid
* The Massachusetts Health Policy Commission is examining data now and will decide what, if any, action needs to be taken

Review: Update from Massachusetts

Massachusetts health care spending
Percent change from previous year



[Source: Boston Globe]

State strategies for health-care cost containment

	Broad strategy	Target
Rhode Island (through OHIC)	**Cap hospital rate increases** to core CPI+1% (~2.8%), eventually falling to CPI, for commercial payors through OHIC rules	No overall target
Massachu-setts	**Set a total cost of care target** and require all payors and providers to commit to controlling cost growth	3.6%
Maryland	**Directly set hospital rates** to reduce health expenses. Eventually, move to global hospital budgets	3.58%
Oregon	**Contract directly with Coordinated Care Organizations,** which are similar to our Accountable Entities[1]	2 points below national average (~3.4%)

1 Currently only for Medicaid, but Oregon has committed to expanding the model to cover Medicare, exchange, and the state employee plan

OHIC's has established a cap on hospital rate increases for the fully-insured commercial market

	OHIC's actions so far
Strategy	• **Cap hospital rate increases to core CPI+1% (~2.8%)**, eventually falling to CPI, for commercial payors through OHIC rules
Enforce-ment	• OHIC has authority over the rates paid by the fully-insured commercial market • The regulation only applies to fully-insured commercial payors, and there is no overall hospital budget target
Other provisions	• Set year-by-year targets for moving from fee-for-service to alternative payment models • Require commercial plans spend a certain percentage (10.8%) on primary care • Target 80% of PCPs part of a patient-centered medical home by 2019

Maryland's approach focuses on hospital rates

	Maryland's approach
Strategy	• **Directly set hospital rates** to reduce health expenses. Eventually, move to global hospital budgets
Enforce-ment	• Hospital rates are directly set by the Health Services Cost Review Commission • Hospitals providing "excessive services" to be fined and have their allowed budget reduced for the following fiscal year
Other provisions	• Hospitals held accountable for quality metrics across all payors (esp. hospital-acquired infections and avoidable readmissions) • Very strong Certificate of Need process • Malpractice reform

How has it worked so far?

- The system was very successful from 1991-1998, but costs have risen in line with national averages since then
- Maryland total health spending is below average for its population, but still above the national average.

Results from Maryland model

TABLE 1-1. Per Capita Personal Health Care Spending and Other Statistics, Maryland, U.S., and Selected States, 1991–2004

	MARYLAND	MARYLAND RANKING AMONG THE 50 STATES	NATIONAL AVERAGE	COLORADO	DELAWARE	MASSACHUSETTS	MINNESOTA	NEW JERSEY	NORTH CAROLINA	OREGON	PENNSYLVANIA	VIRGINIA	WISCONSIN
PER CAPITA SPENDING, 2004	$5,590	17	$5,283	$4,717	$6,306	$6,683	$5,795	$5,807	$5,191	$4,880	$5,933	$4,822	$5,670
AVERAGE ANNUAL GROWTH													
1991–1998	4.2%	44	4.8%	4.0%	5.6%	5.2%	5.8%	5.0%	6.2%	5.5%	4.5%	4.6%	5.0%
1998–2004	7.2	13	6.3	6.4	7.3	6.2	7.2	5.8	7.2	6.6	6.7	6.8	7.6
SOURCE OF PAYMENT, 2004													
Medicare share	18.8	23	19.6	15.4	18.2	18.4	15.0	20.7	19.1	18.3	21.7	17.1	16.2
Medicaid share	14.0	35	17.4	11.4	14.2	19.3	17.7	14.6	18.3	13.9	17.5	10.5	13.7
TYPE OF SERVICE, 2004													
Hospital share	37.2	24	36.6	35	36.7	39.2	33.9	33.8	36.8	34.2	36.4	37.1	37.3
Physician share	25.4	19	25.4	29	23.5	21.2	26.3	24.3	23.1	29.4	23.1	25.6	27.1
Drug share	14.8	21	14.3	11	14.7	12.7	12.3	16.5	16.8	11.7	15.1	15.7	12.3

SOURCE: Centers for Medicare & Medicaid Services, National Health Expenditure Data. http://www.cms.hhs.gov/NationalHealthExpendData/05_NationalHealthAccountsStateHealthAccountsResidence.asp#TopOfPage

Oregon is focusing on Coordinated Care Orgs

	Oregon's approach
Strategy	• **Contract directly with Coordinated Care Organizations,** initially for the Medicaid program, but growing to cover Medicare, exchange, and the state employee plan
Enforce-ment	• CCOs receive performance bonuses for keeping costs below the benchmark • Contracts with CCOs with above-average costs may not be renewed

Other provisions	• Strong metrics evaluating all aspects of care:
	  • Improve behavioral health coordination
	  • Improve peri-natal care
	  • Reduce preventable readmissions
	  • Ensure care is delivered in appropriate settings
	  • Improve primary care
	  • Deploy care teams focused on super-users
	  • Address population health

What is a Coordinated Care Organization?

- CCOs are a type of Accountable Entity
- Patients are assigned a PCP to ensures efficient, coordinated care
- In Oregon, CCOs began by receiving fee-for-service. They are slowly transitioning to a capitation model

Questions for Rhode Island (1 of 2)

Is a health spending cap right for Rhode Island?

Design considerations	Possibilities
* What services should fall within the cap?	* All healthcare services statewide * All insured services * Hospital services only
* What should the cap's target be? * Should we phase-in the cap?	* Historical healthcare growth rate (~5%) * Growth of the state's economy (~3.5%) * Inflation (~2%)
* How will we enforce a cap?	* "Soft cap" with no direct enforcement * Require excessive increases to be justified in a performance improvement plan * Monitor payors and providers who exceed the cap * Directly regulate rates or budgets to ensure compliance

Questions for Rhode Island (1 of 2)

Is a health spending cap right for Rhode Island?

Design considerations	Possibilities
* How will we help the system fall within the cap?	* Encourage rapid shift to capitation and Accountable Entity models * Improve interoperability and use of health IT * Encourage all plans assign members to a PCP
* How else can the state help make a cap a success?	* Expand DOH's Center for Health Data and Analysis to examine evidence-based methods of reducing health trends * Hold annual cost trend hearings * Ensure providers are maximizing scope of practice * Improve price transparency for consumers * Reduce waste and overcapacity

Questions?

Discussion

Public Comment

Thank you!

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