

Working Group for Healthcare Innovation

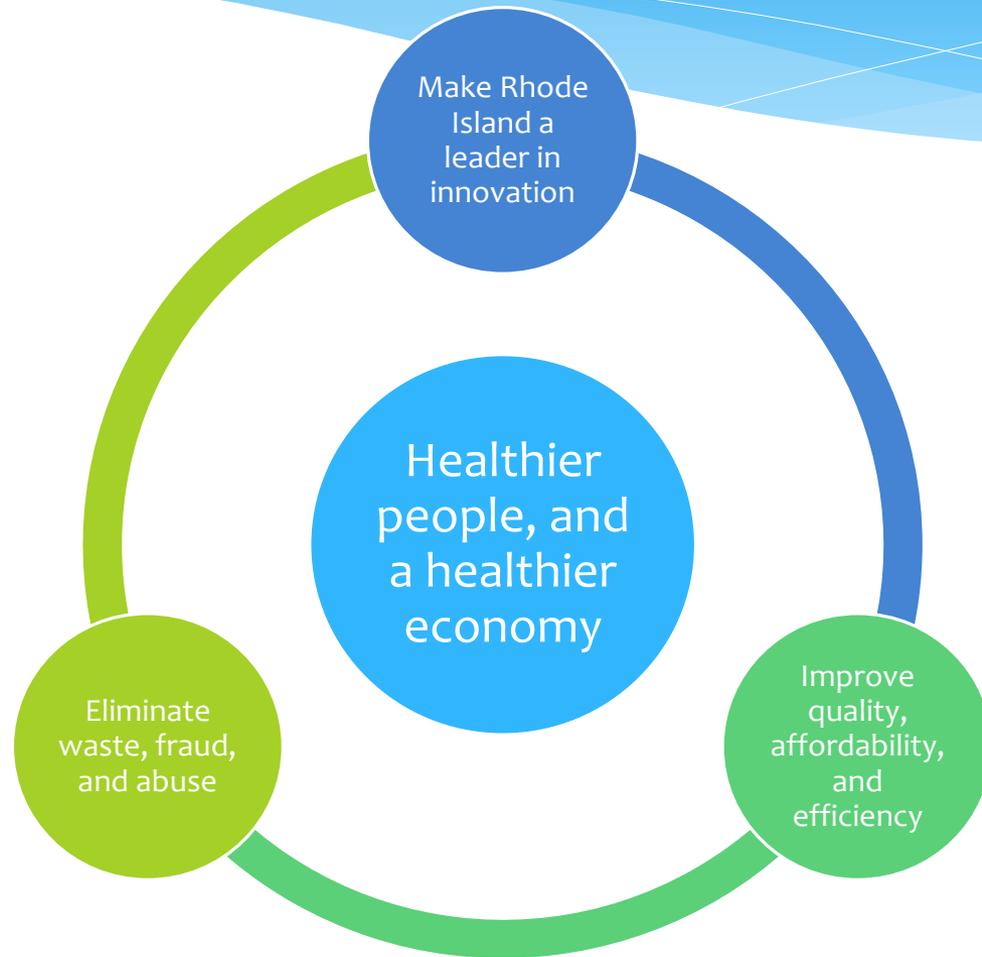
<http://www.governor.ri.gov/initiatives/healthcare/>

Meeting #1
August 19, 2015

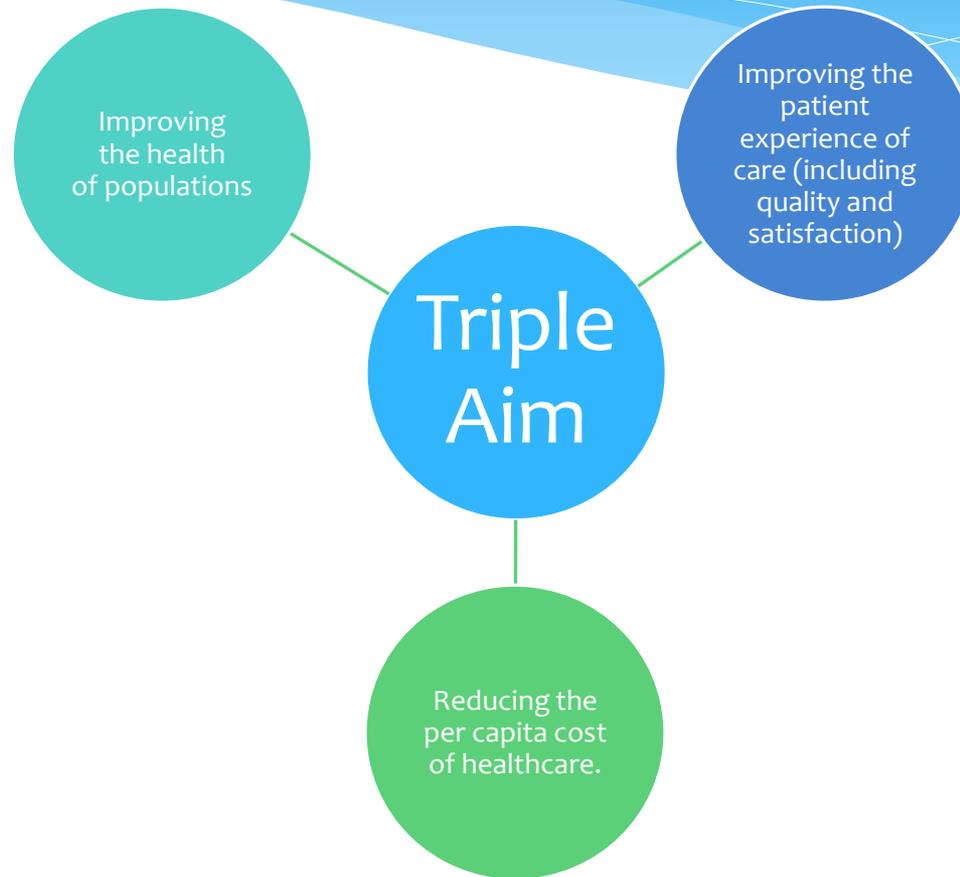
Agenda

Welcome	Elizabeth Roberts Secretary, EOHHS
Introduction to the Working Group	Elizabeth Roberts Secretary, EOHHS
Lessons learned from the Massachusetts experience	David Cutler Professor, Harvard University
Public Comment	-

Better care, healthier people, stronger Rhode Island

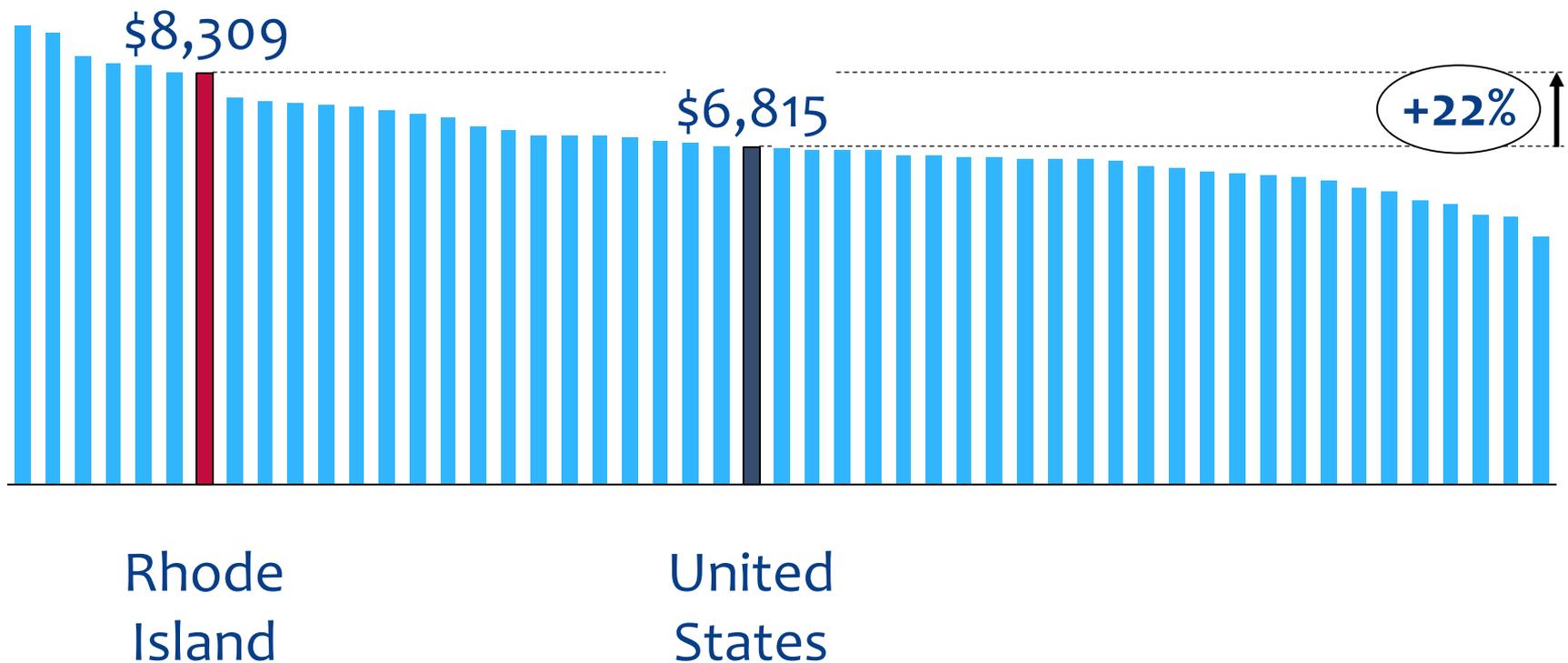


The Triple Aim



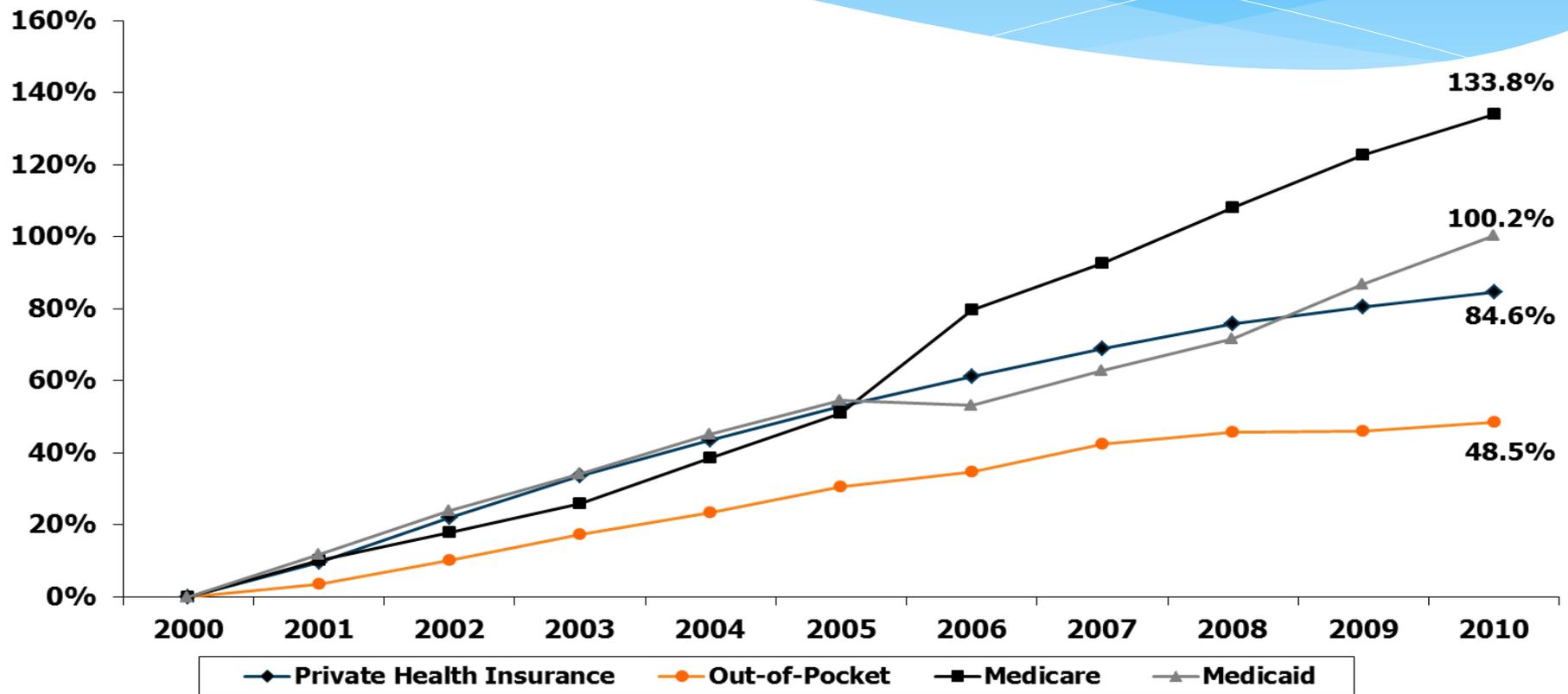
High healthcare costs are a major concern for Rhode Islanders

Healthcare expenditure per capita, 2009



[SOURCE: KAISER FAMILY FOUNDATION, 2009]

Cumulative growth in national health expenditures, 2000-2010



Source: Kaiser Family Foundation calculations using NHE data from Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, at <http://www.cms.hhs.gov/NationalHealthExpendData/> (see Historical; National Health Expenditures by type of service and source of funds, CY 1960-2010; file nhe2010.zip).

Despite this, the state does not track total statewide health expenses

- * **The state** needs data on current trends to determine policy
- * **Businesses** need predictability in their healthcare expenses for employees
- * **Families** need to know they can afford their health expenses, which are increasingly out-of-pocket

The Health Care Planning and Accountability Advisory Council (HCPAAC) commissioned a total cost of care study and other studies to address this gap

What drives
healthcare
costs?

High
utilization

Aging
population

Lack of care
coordination

Expensive
services

Senator Whitehouse & other health leaders set out a framework for reform

- * **Establish a coordinated statewide payment reform plan** to incentivize collaboration and reduce waste
- * **Set bold and specific targets** for a statewide global health spending cap as well as reductions in fee-for-service and increases in value-based payments
- * **Hold providers accountable for statewide quality metrics** around avoidable hospital admissions, emergency room usage, and health IT

Building on success

Health reform groups

- * Reinventing Medicaid Working Group
- * Health Care Planning and Accountability Advisory Council (HCPAAC)
- * Care Transformation Collaborative
- * Accountable Care Organizations
- * Health Information Technology, both through RIQI and provider initiatives
- * RIBGH Choosing Wisely initiative
- * SIM

HCPAAC has been highly involved in this area, providing much of our data:

- Primary care study
- Hospital capacity study
- Behavioral health study
- Total cost of care study

The Process

The Working Group for Healthcare Innovation

- * Governor Raimondo established the Working Group through Executive Order 15-13 on July 20th to recommend changes across the entire healthcare system, both public and private
- * The Working Group will be assisted by a Provider Advisory Group, which is being assembled now

Goals of the Working Group

Develop benchmarks and a plan to establish a **global health spending cap** for Rhode Island

Identify a plan to **tie 80% of payments to quality** by 2018

Improve access to care for all Rhode Islanders, including people in disadvantaged communities

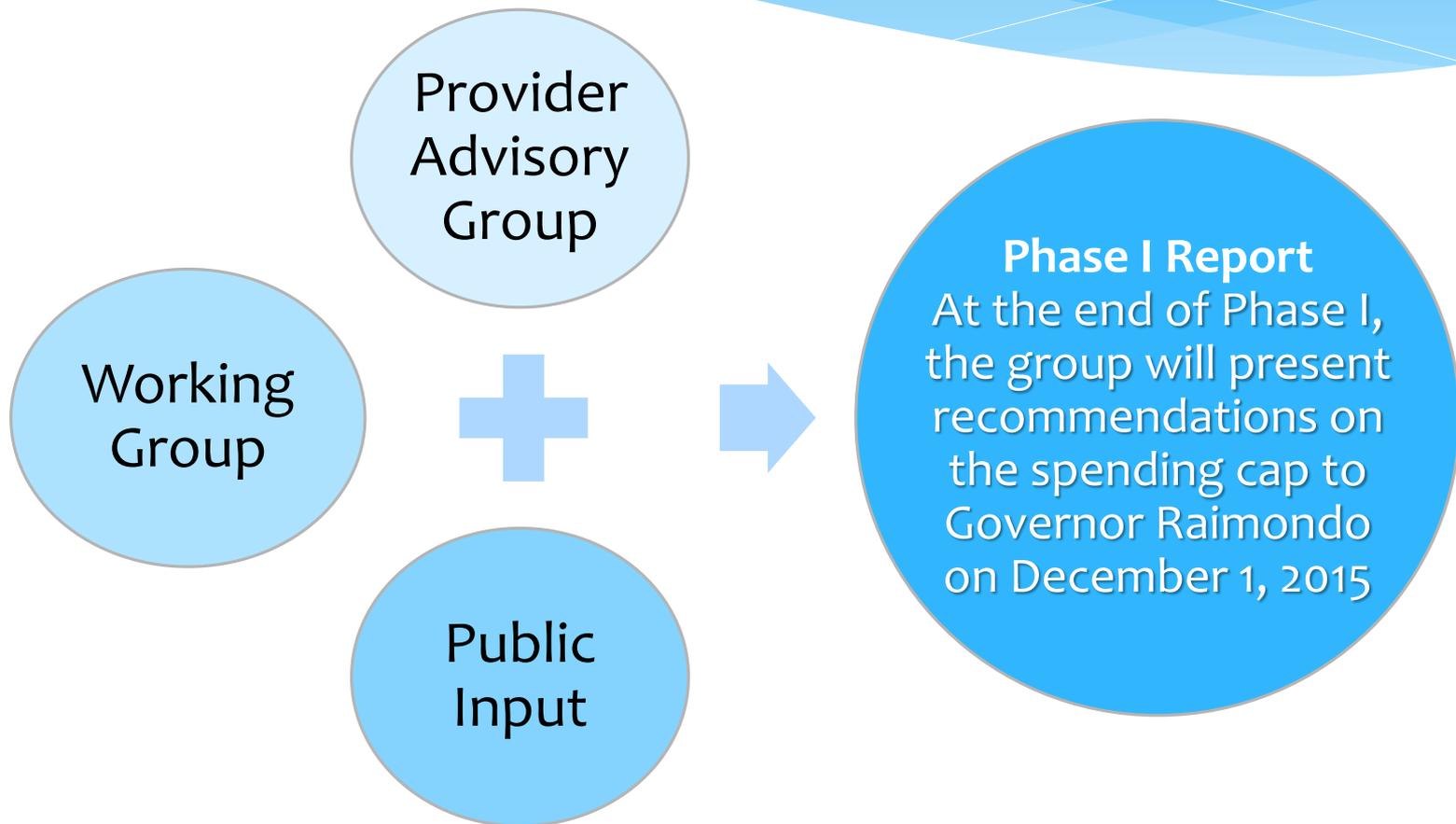
Executive Order 15-13 signed on July 20, 2015 established the Working Group with several goals

Develop a vision for **next-generation health information technology** to improve care

Establish **population health** and wellness goals

Identify opportunities to **reduce waste and overcapacity**

The Process



Our Tools

Tools

Studies

- * Total cost of care study
 - * Behavioral health study
 - * Hospital capacity study
-

Data sources

- * All-payor claims database
 - * Hospital discharge database
 - * Medicaid data
-

Public input

- * Provider Advisory Group
- * Other expert advice
- * Public comments

Timeline

Public Listening Sessions

- September 15 & September 22
6:00 – 7:30pm, Location TBA

Working Group

- August 19, October 7,
November 4 and December 1
All 4:00-6:00pm, Locations TBA

Timeline

Working Group meetings

- **August 19, 2015:** Is a health spending cap right for Rhode Island?
- **October 7, 2015:** Healthcare trends in Rhode Island
- **November 4, 2015:** Paying for value, not volume
- **December 1, 2015:** Issue recommendations on spending cap

Membership

Elizabeth Roberts, Chair
Secretary, EOHHS

- Laura Adams
- Edward Almon
- Peter Andruszkiewicz
- Mayor Scott Avedisian
- Al Ayers
- Dr. Timothy Babineau
- Dr. Steven Brown
- Albert Charbonneau
- Dr. Jack Elias
- Steven Farrell
- Diana Franchitto
- Louis Giancola
- Hugh Hall
- Jane Hayward
- Steven Horowitz
- Dennis Keefe
- H. John Keimig
- Dr. Dale Klatzker
- Dr. Alan Kurose
- Dr. Elizabeth Lange
- Dr. E. Paul Larrat
- Peter Marino
- Linda McDonald
- Rep. Joseph McNamara
- Sen. Josh Miller
- Dr. Alvaro Olivares
- Sen. Juan Pichardo
- Donna Policastro
- Dr. Albert Puerini
- Dr. Louis Rice
- Dr. Pablo Rodriguez
- James Roosevelt
- Samuel Salganik
- Lester Schindel
- John Simmons
- Rep. Joseph Solomon
- Neil Steinberg
- Dr. Robert Swift
- Reginald Tucker-Seeley
- Dr. Ira Wilson

Questions?

Presentation by Professor David Cutler

- * Otto Eckstein Professor of Applied Economics,
Harvard University
 - * Secondary appointments at Kennedy School of
Government and School of Public Health
- * Senior Health Care Advisor to Obama Campaign
- * Member of MA Health Policy Commission
- * Research Associate with National Bureau of Economic
Research

Policies to Slow the Growth of Medical Costs



David M. Cutler
Department of Economics
Harvard University
david_cutler@harvard.edu

August 2015



The Need for Cost Reductions

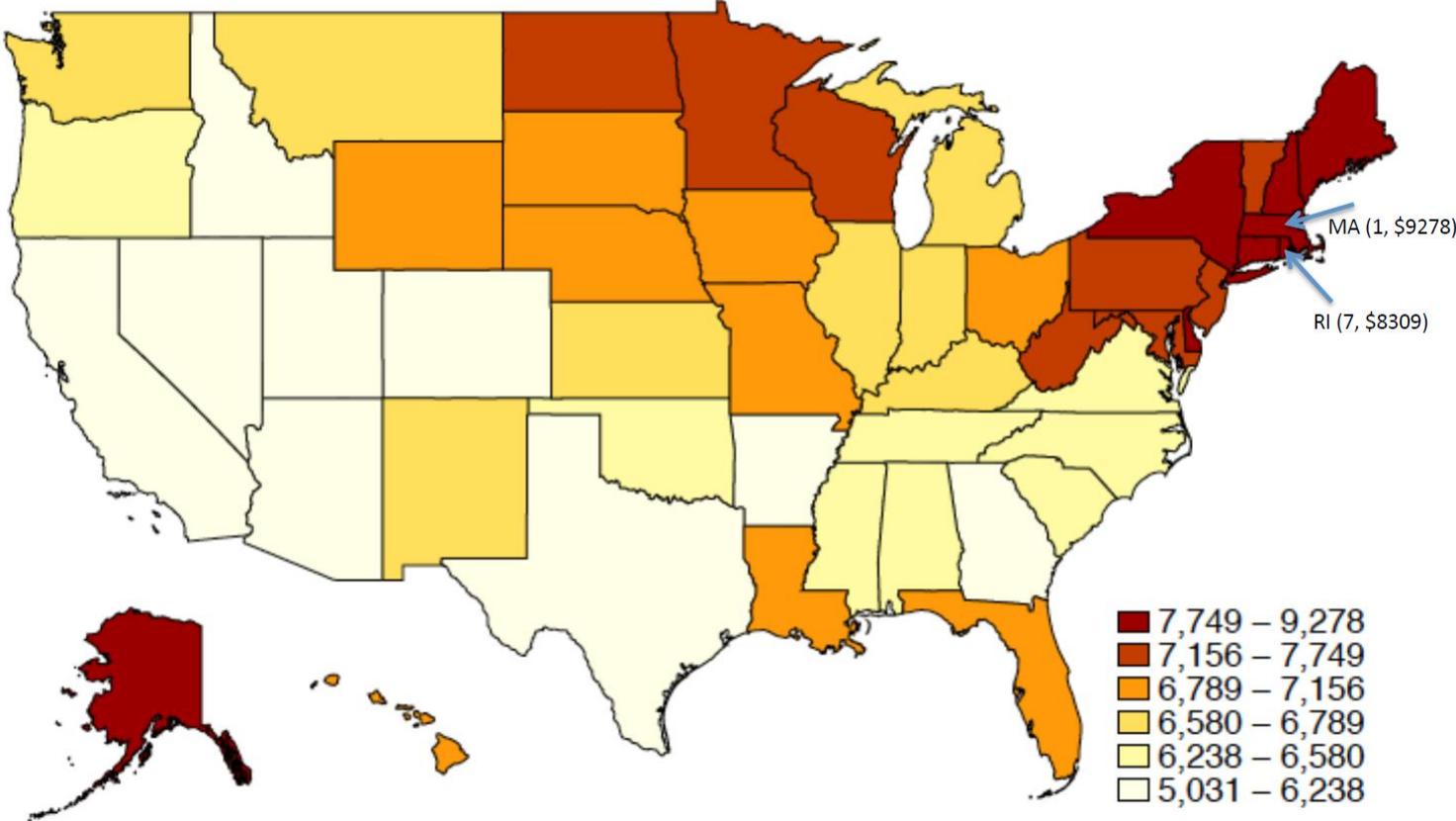
With insurance coverage close to universal, attention necessarily turns to costs.

In MA, a series of acts, culminating in an ambitious cost control bill.



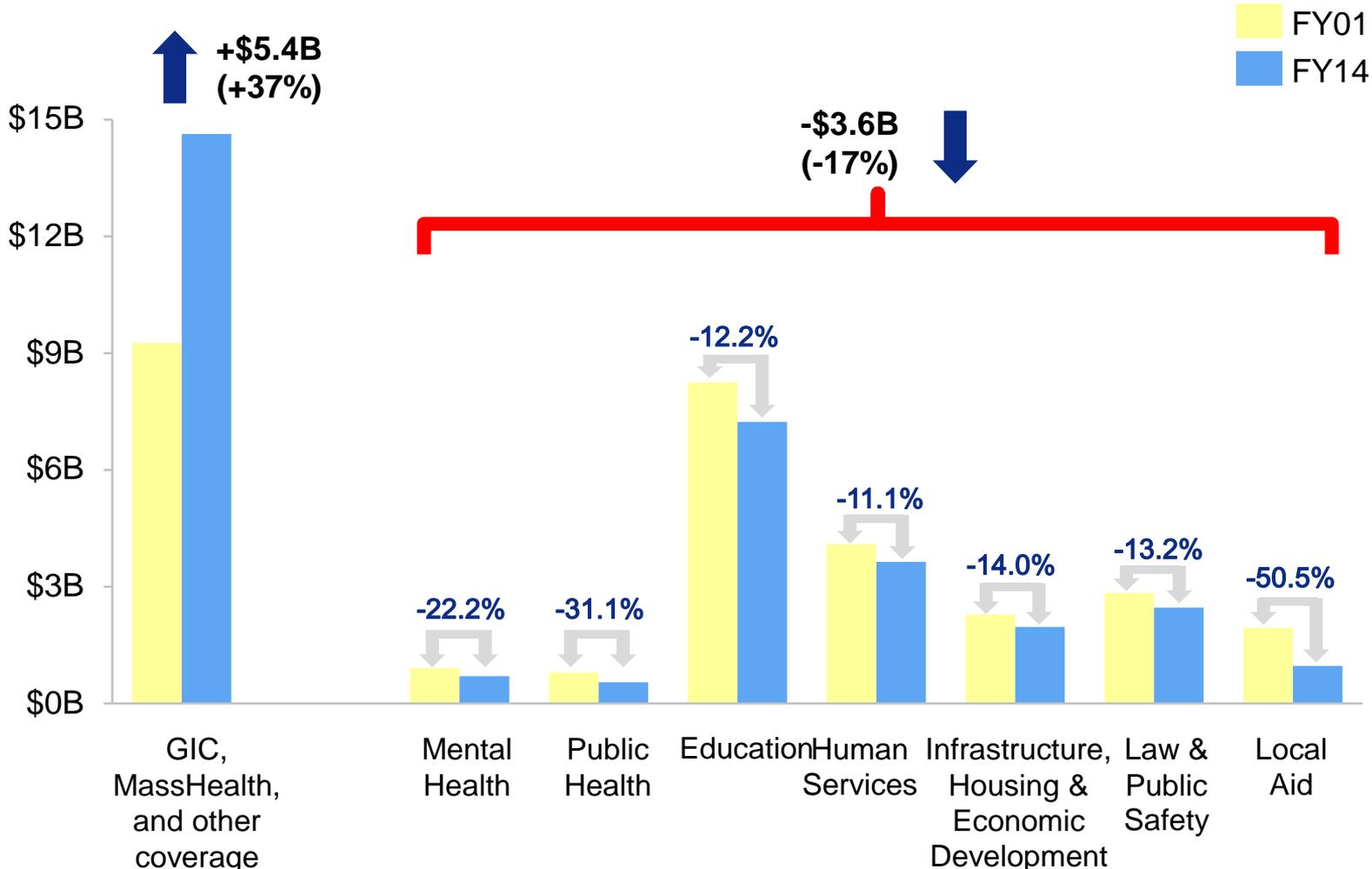
Massachusetts is the most expensive state; Rhode Island is 7th

Per Capita Medical Spending by State, 2009



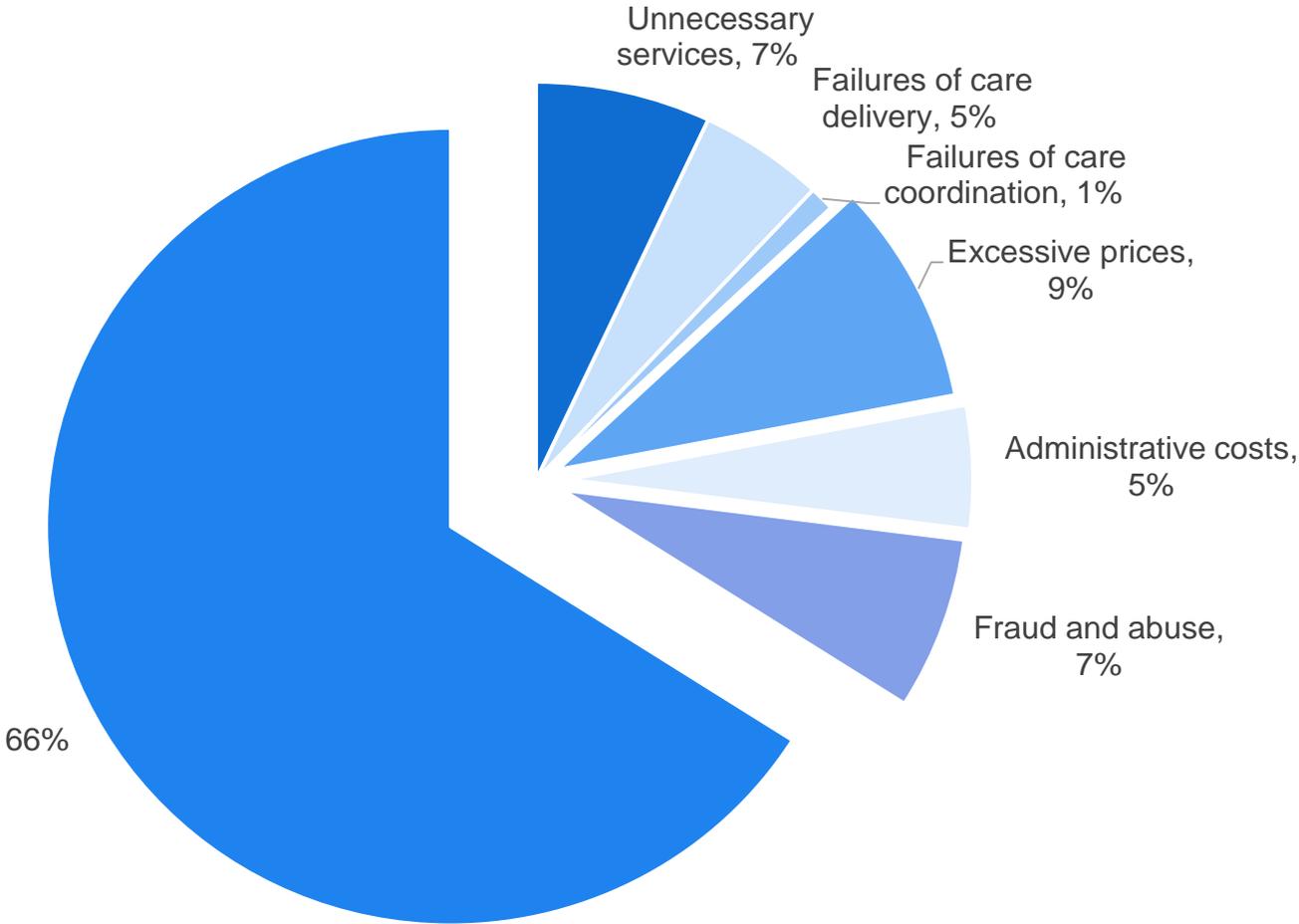
Medical care is ruining the state budget - FY01 vs. FY14

Billions of dollars

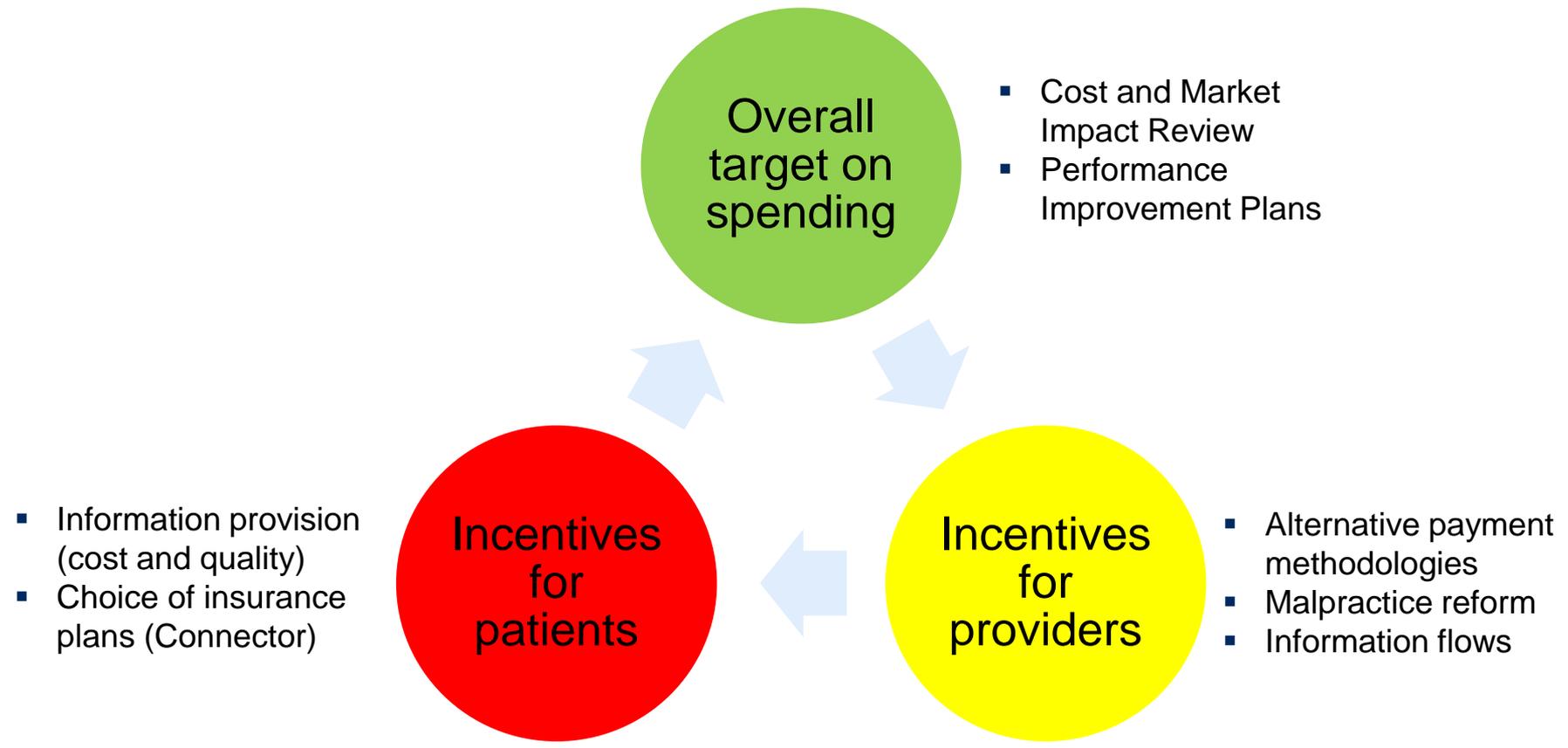


Note: Figures all adjusted for GDP growth
 Source: Massachusetts Budget and Policy Center

There is enormous waste in medical care

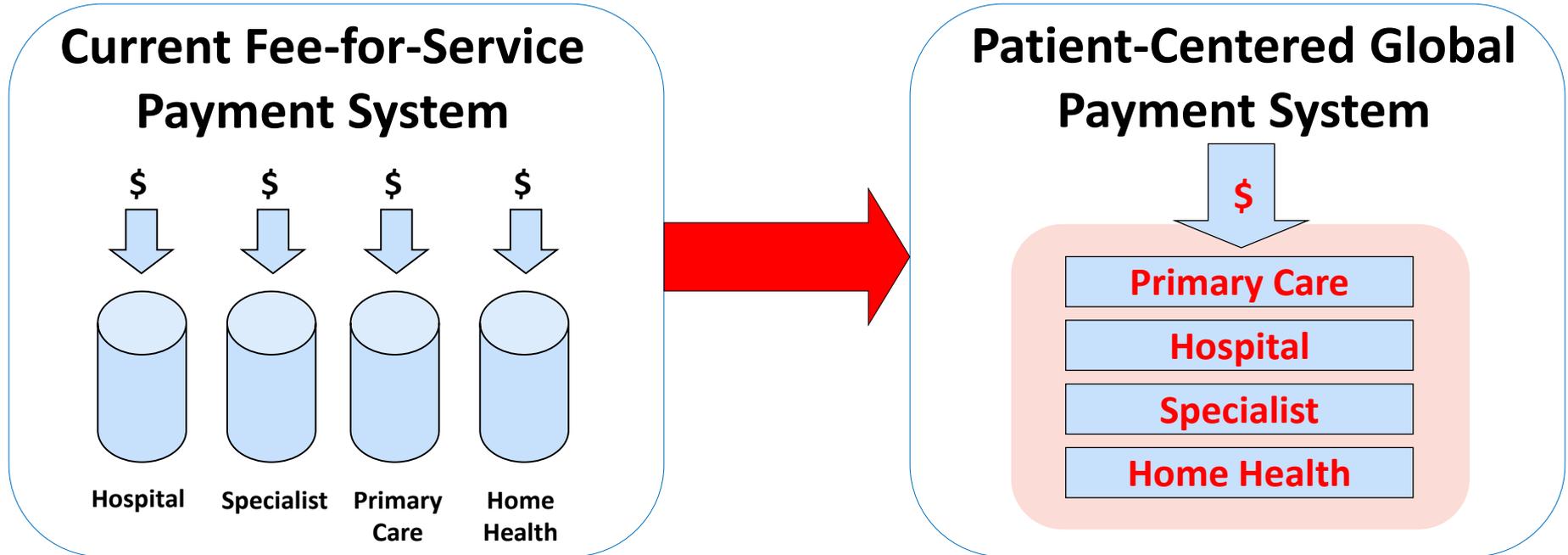


The Massachusetts Strategy



Payment reform

- Move to 'alternative payment systems'
- Primary care, specialty care, and fully integrated care



The Target

Benchmark	Approximate magnitude
Premiums	8.0%
Forecast medical spending per capita	5.5% - 6.0%
Forecast GSP per capita	3.6%
Inflation rate	2.0%

Target:

2014-2017

2018-2022

2023-

Potential GSP

Potential GSP - .5%

Potential GSP

The target

- Per capita medical spending in the Commonwealth as a whole
- Includes all services that are measured – inpatient, outpatient, pharma, post-acute
 - Excludes services not running through insurance.
- All payers (cost shift doesn't affect total)
- Sets a clear goal for contracting

Formalities

- Target is growth of potential Gross State Product (PGSP)
- Set by House and Senate budget committees and ratified by Health Policy Commission
- Performance is measured by Center for Health Information and Analysis

If the target is not met:

- CHIA makes determination about why target was not met
- Performance Improvement Plan (PIP) filed by identified organization and approved by Health Policy Commission (HPC)
- Penalties are minimal; real threat what subsequent steps would be taken

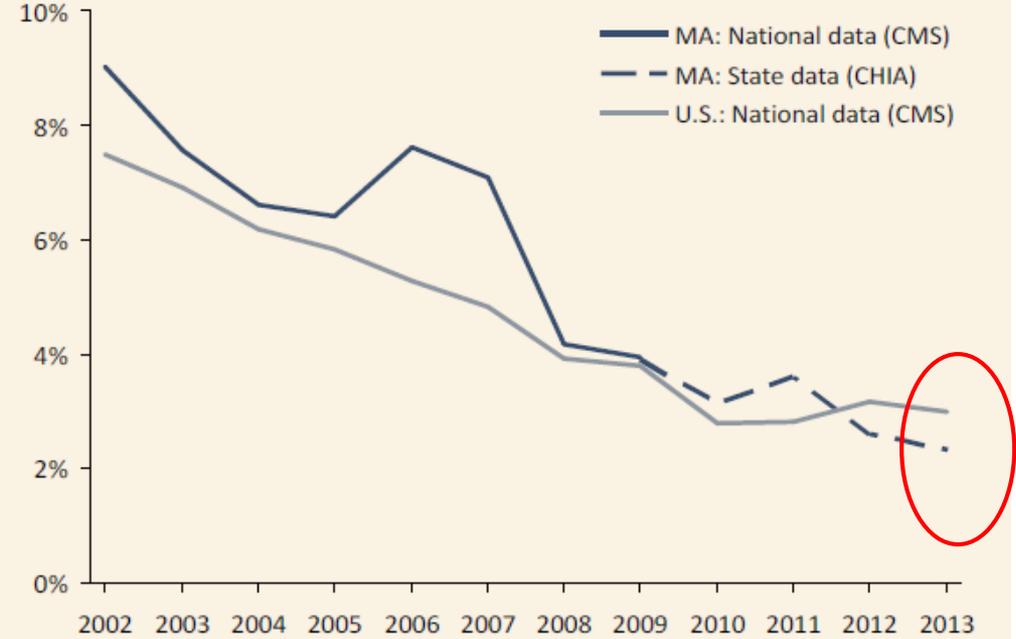
Impact so far

Metric	Grade
Costs relative to target	●
Increased use of APMs	●
Taking out clinical waste	●
Availability/use of appropriate data	
- clinical	●
- individual/family	●

Health care spending growth has slowed

Figure 2.3: Annual growth in per-capita healthcare spending: Massachusetts versus the U.S.

Percentage growth from previous year, 2002- 2013

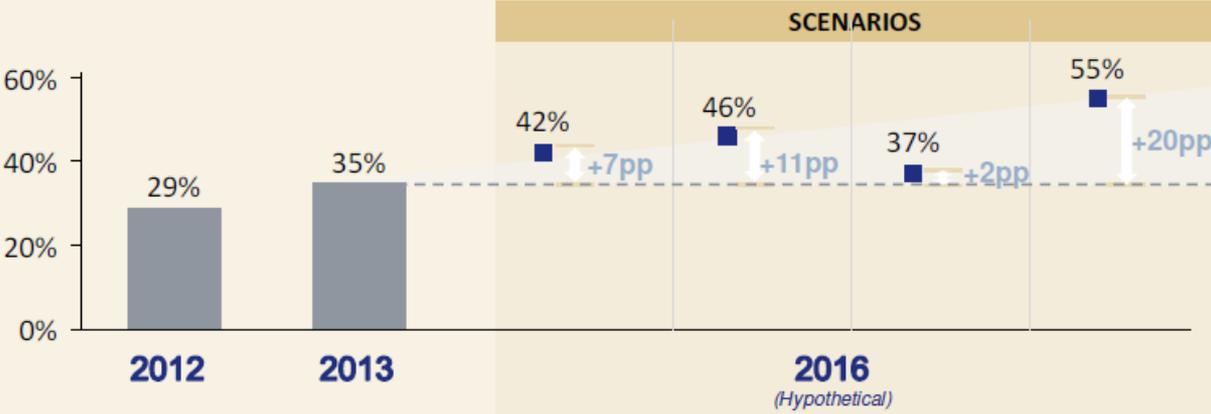


NOTE: Solid lines indicate CMS data; dashed line indicates Massachusetts-specific data. Specifically; CMS NHE & SHEA 2002-2009, US NHE 2009 – 2013, MA TME 2009 – 2012, MA THCE 2012-2013

SOURCE: Centers for Medicare & Medicaid Services, Massachusetts Center for Health Information and Analysis, United States Census Bureau

Growth of Alternative Payment Methods

Figure 8.3: Statewide use of APMs and projected growth under four scenarios
 Percentage adoption of APMs across all payers, 2012 and 2013 (actual), 2016 (hypothetical)

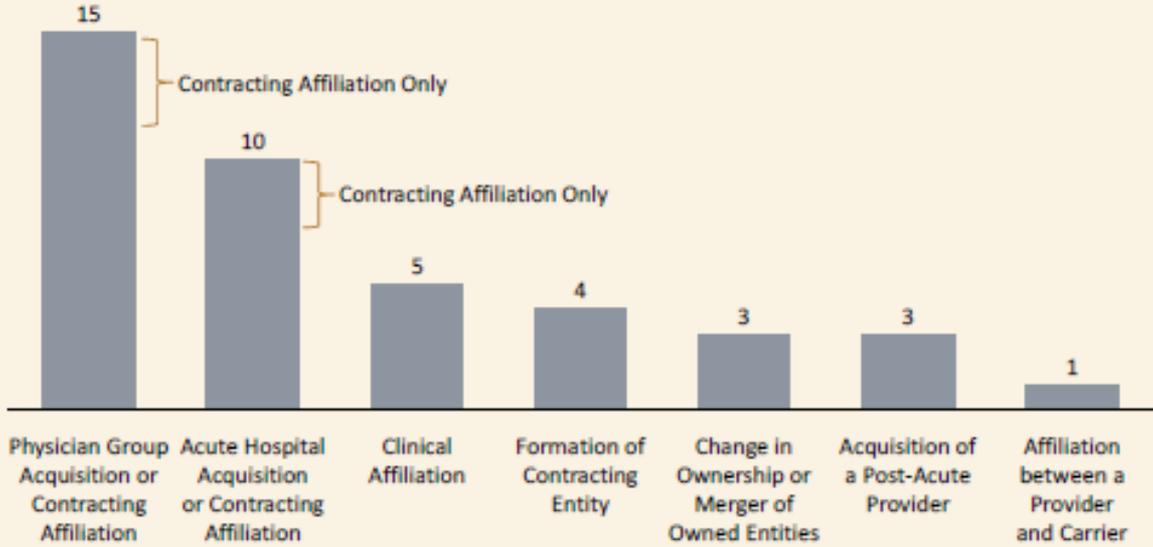


SCENARIO DESCRIPTIONS				
	HMO	PPO	ACO	Additive
Assumptions	All payers expand APMS in HMOs to close 2/3 of gap between 2013 coverage and 90% (BCBS rate)	All payers expand APMs in PPOs to half of their projected HMO rate	MassHealth expands APMs (via ACO) to close 1/3 of gap between 2014 coverage and 100%	HMO +PPO +ACO
Projected impact	+7pp	+11pp	+2pp	+20pp

NOTE: See Technical Appendix B8.
 SOURCE: Center for Health Information and Analysis 2014 Annual Report Alternative Payment Methods Data Book, 2013; Center for Health Information and Analysis 2013 Alternative Payment Methods Baseline Report Data Appendix, 2012; Centers for Medicare & Medicaid Services Shared Savings Program Performance Year 1 Results; Other Centers for Medicare & Medicaid Services data; Mass-Health personal communication

Material Change Notices Received

Figure 2.9: Frequency of provider alignment types for which the HPC received Material Change Notices
Number of transactions received April 2013 through December 2014



NOTE: HPC received notice of 33 transactions, in total, between April 2013 and December 2014. Some transactions involve more than one type of provider alignment.

SOURCE: Material Change Notice Filings, Health Policy Commission

Public Comment

Thank you!

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