Peterson-Milbank
Program for Sustainable
Health Care Costs

Case Study
January 2021

Rhode Island's Cost Trends Project: A Case Study on State Cost Growth Targets

Erin Taylor, MPH, Michael Bailit, MBA, Megan Burns, MPP, and Justine Zayhowski, MPP

Policy Points

- A health care cost growth target forms the basis for accountability for spending growth at the state, provider, and insurer levels.
- Rhode Island's experience highlights how a small team of state staff, engaged state and private sector leadership, and committed stakeholders can address rising health care costs.

EXECUTIVE SUMMARY

State efforts to curb health care cost growth have largely focused on Medicaid and public employee benefits programs because states have direct purchasing control over those programs and responsibility to manage costs for individuals enrolled in them. Governors and legislators are now considering strategies to constrain *total health care spending* statewide, across all populations. As health care spending takes up a greater portion of state and local budgets, employer budgets, and personal income, there are fewer dollars for other uses. At the state and local level, health care spending can crowd out funding for other public services, such as housing or nutrition, which are both important to improve population health.

Addressing growth in health care spending requires a system-wide view and the collective action of payers and stakeholders. States are leading the way by setting health care spending targets, developing new capabilities to collect and analyze data, and forging strong partnerships with stakeholders to make sure there is buy-in and trust in the resulting actions.

Rhode Island is among a few states that have implemented a cost growth target to stimulate action to improve health care affordability and curb health care spending growth. Massachusetts and Delaware are the two other states that first established a target for health care spending growth. A cost growth target is an expected rate of annual per capita growth of total health care spending in a state. The target itself forms the basis for accountability for spending growth at the state, insurer, and provider levels.

Setting a cost growth target alone is unlikely to slow the rate of health care spending growth. Rhode Island recognized this and pursued parallel strategies to analyze cost growth and drivers of cost growth. The state engaged leaders in the health care industry to develop the target, pursue a complementary data strategy to analyze factors contributing to health care spending growth, and then take action.

Through a public–private partnership, and with funding from the Peterson Center on Healthcare, Rhode Island established the Health Care Cost Trends Project (Cost Trends Project) in 2018 to address health care cost growth and set a cost growth target. This partnership underscored the commitment of state officials and industry leaders to address the affordability of health care for consumers, businesses, and the state.

The project has involved several key steps, from convening a stakeholder group to selecting a cost growth target methodology to recommending policy actions based on the data (Figure 1). Rhode Island's experience highlights how the resolve of a small team of state staff, engaged and effective state and private sector leadership, and a shared commitment of stakeholders can address rising health care costs. It also provides important insights for other states considering a cost growth target, such as the value of providing reporting guidance on data submission to insurers and developing a data validation process.

INTRODUCTION

Commercial health care cost growth in Rhode Island has exceeded the growth rate of the state's economy, and both employers and employees are seeing a greater portion of their revenue and income go to health care.[1] State budgets are also strained under rising health care costs, which are crowding out investments in other public and social services. This mirrors a national trend of health care expenditures increasing at a faster rate than the national gross domestic product.[2] To cover ever-increasing health care costs, states may face decisions about cutting spending in other critical sectors that directly impact health outcomes, such as housing and nutritional programs.

Recognizing that rising health care costs restrict public and private investments in other areas, Rhode Island developed and implemented a strategy in 2018 to address total health care spending in the state. Rhode Island followed Massachusetts and Delaware to become the third state to design and implement a health care cost growth target.[3] A cost growth target is an expected rate of annual per capita growth of total health care spending in a state. Like those in Massachusetts and Delaware,

Figure 1. Key Components of Rhode Island's Cost Trends Project

Engaging Stakeholders in an Advisory Role	▪ Public and private leadership signaling strong commitment to the project ▪ Meaningful engagement of representatives from across the health care market ▪ Shared understanding and pursuit of a common goal to curb health care spending ▪ Participant familiarity with cost growth target and related strategies
Developing a Cost Growth Target Methodology	▪ Choice of indicator (e.g., Consumer Price Index) to select to benchmark spending growth ▪ Choice of populations to include and determination of whether there are reliable data ▪ Options for state authority for the cost growth ▪ Accountability for performance against target
Building Capacity to Analyze Cost Growth Drivers and Spending Growth	▪ Data specifications and technical guidance ▪ Data sources for aggregate and detailed analyses ▪ Data validation processes for payer-reported and APCD data
Using Data to Drive Action	▪ Development of a data use strategy with stakeholder input ▪ Production of meaningful and actionable information and reports ▪ Recommendation of targeted strategic interventions informed by data

Rhode Island's cost growth target is based on the state's economic growth forecast.

This case study offers insights for other states considering how to address unsustainable rates of health care spending growth. It describes Rhode Island's experience establishing a cost growth target and its major policy and implementation decisions. The case study also reviews Rhode Island's development of a complementary strategy to analyze factors influencing health care spending to inform action.

Establishing the Health Care Cost Trends Project

Through a public–private partnership, and with funding from the Peterson Center on Healthcare, Rhode Island established the Health Care Cost Trends Project (Cost Trends Project) in 2018 to address health care cost growth. A primary feature of the Cost Trends Project is Rhode Island's health care cost growth target.[4] In developing its target, Rhode Island considered the experience of other states with similar initiatives, especially Massachusetts, which was the first state to operationalize a health care cost growth target. States' efforts to contain health care costs have largely focused on their Medicaid or employee benefits programs, areas in which states have direct purchasing control. Rhode Island's Cost Trends Project sought to address total health care spending across all populations and service categories. The Cost Trends Project also endeavored to leverage data and analytics to inform action by the state, insurers, and providers to meaningfully address health care spending and improve system performance.

Rhode Island's governor prioritized the development of a cost containment strategy that included a cost growth target as a mechanism to control spending. The governor directed the Office of the Health Insurance Commissioner (OHIC) and the Executive Office of Health and Human Services (EOHHS) to lead the effort on behalf of the state. External contractors, including a leading research university in the state, provided technical assistance, process support, and data analytics expertise.

The Peterson Center on Healthcare provided financial support for robust analytic capacity to examine health care costs, identify core drivers of cost growth, and develop a plan for sustained data analysis.

Kick-Starting the Cost Trends Project

The Cost Trends Project was the result of years-long stakeholder work and health care sector collaboration with public officials. In 2014, a coalition of industry leaders issued a set of health care reform recommendations, including one that called for state and health care leaders to "collect the necessary data to establish a strategy to control costs and examine various options, such as linking health care inflation to Gross State Product."[5] Using those recommendations as a blueprint, Governor Gina Raimondo in 2016 convened a working group of the state's health care provider and insurer leaders to advise the administration on the adoption of a cost growth target as a health care cost containment strategy. Following a series of five meetings, the working group submitted recommendations to the governor, concluding that the state should only pursue a cost growth target strategy if it took parallel action to:

- rigorously analyze drivers of cost and cost growth;
- facilitate collaborative action addressing system performance improvement opportunities; and
- supplement the cost target with other non-cost performance targets such as population health and clinical outcomes of care.

Convening the Cost Trends Project Steering Committee

The governor's office, with input from OHIC and EOHHS, called on members of the state's health care community to participate in a steering committee to guide the Cost Trends Project work. The health insurance commissioner and secretary of health and human services co-signed individual letters to steering committee members formalizing their participation and establishing clear expectations about the role and tasks of the committee. The state appointed a health insurance executive and a medical group executive to serve as co-chairs with the health insurance commissioner. The co-chairs

expressed strong support for the state's prioritization of health care cost containment, and their past demonstrated leadership in the state conferred additional legitimacy to the project.

Steering committee members were intentionally selected to represent diverse entities and perspectives including government, business, consumers, and community leaders, though the composition of the committee is balanced more toward payers and providers.

Key Takeaways and Insights: There are many factors that contributed to the steering committee's effectiveness, including:

Public and private leadership: Steering committee members included supportive, high-profile, and respected leaders in the state's health care community. At the state level, the governor, commissioner of health insurance, and secretary of health and human services all expressed strong support, with the commissioner taking the most active role as co-chair of the steering committee. This conferred legitimacy to the project and signaled the importance of addressing health care spending through a cost growth target.

Shared purpose: Steering committee members aligned around the goals of the Cost Trends Project, particularly the development of a cost growth target to curb spending growth and thereby support affordability. This helped to focus the steering committee's work.

Culture of collaboration: Strong, pre-existing working relationships and a culture of collaboration were instrumental. Many steering committee members were involved in the governor's 2016 working group, which shaped the Cost Trends Project. Early and ongoing public and private collaboration and a willingness to engage in a cooperative and productive way helped the group acknowledge and work through policy decisions. Familiarity and prior involvement of steering committee members in discussions of a target allowed the work to move faster than if the topic had been introduced as a new concept.

As the state transitioned from development to implementation of the cost growth target, it expanded the stakeholders involved to include representation from large businesses, community non-profit organizations, a long-term care organization, and the pharmaceutical industry. The steering committee has also expressed an interest in including an economist in future discussions.

Developing a Cost Growth Target Methodology

The primary task of the Cost Trends Project was to develop a methodology for setting a cost growth target. The steering committee accomplished this in four months, an accelerated timeline. Familiarity with the topic and a willingness to commit to the state's aggressive meeting schedule enabled the steering committee to complete required work in the short time frame.

The project's external contractor structured meetings around a series of cost growth target "design decisions," including insights into other states' approaches, that the steering committee discussed. Co-chairs reviewed discussion documents in advance of each meeting so that they were prepared to facilitate decision-making and consensus-building.

> **There is a true desire to do something different, and passion to do it collectively. The governor commissioned us, but we are driving our own destiny for the state. We are leading and not having something done to us.**
>
> **Kim A. Keck, former President and Chief Executive Officer, Blue Cross & Blue Shield of Rhode Island, former Cost Trends Project Steering Committee Co-Chair**

Key Takeaways and Insights: The following contributed to the steering committee's success in setting a cost growth target in a compressed timeline:

- Prior awareness of a cost growth target;
- Application of experience and lessons of the approach in Massachusetts;
- Extensive meeting preparation, planning, and other project management work; and
- Prioritization among participants of an intensive planning and engagement process.

For most states, a six-month timeline would likely be more feasible.

A description of the key design decisions the steering committee made as it developed the cost growth target methodology follows.

a. Scope of the cost growth target strategy

A cost growth target can stand alone or be pursued in conjunction with other state strategies to constrain health care costs. States should establish the scope of a cost growth target and its relationship to other state initiatives early in the planning process. The Rhode Island Cost Trends Project adopted a singular strategy to develop its cost growth target. (Notably, Rhode Island employs complementary strategies to the cost growth target, but they preceded the target.)

Standalone cost growth target strategy: States can pursue a cost growth target as a standalone cost containment strategy in which they set the value of the target, and measure and report performance relative to the target. A standalone cost growth target can, however, be accompanied by other activities to extend the target's reach. These other actions may include: (a) an extensive transparency strategy, (b) a "data use" strategy to help understand cost growth drivers and to identify opportunities for intervention and improvement, and (c) stakeholder engagement in independent and collaborative work to address underlying drivers of spending. Rhode Island took this approach.

Singular component of a larger cost containment strategy: Other states may take a broader view and integrate a cost growth target with additional cost containment strategies. For example, Oregon's legislation combined a cost growth target with expanded use of value-based payment.[6] Similarly, Pennsylvania's Governor Tom Wolf announced a health reform plan that includes increasing affordability through a cost growth target strategy combined with other initiatives to address health disparities and increase affordability.[7]

Complementing a cost growth target with other cost-focused initiatives may help with target attainment, but it also places a larger administrative and political challenge before the state.

b. Determining the basis upon which to set the target

After considering tying spending growth to household income, personal income, or inflation growth, the steering committee recommended basing the target on per capita potential gross state product (PGSP) growth, concluding that it most closely aligned with a goal of making sure that health care did not take up an increasing portion of the state's budget. The 2019–2022 cost growth target in Rhode Island is set to the value of the state's PGSP (3.2% annually). (Table 1 presents a summary of the considerations for the different approaches.)

Before a state sets the value of a cost growth target, it must assess the per capita rate at which health care costs have been growing. This requires collecting and analyzing the best available data to understand the full view of total health care costs and comparing the data to the values produced by the benchmarking indicator options.

c. Populations to include in the spending calculation

States need to determine the population(s) for which spending will be measured relative to the cost growth target. The size of different populations and the reliability of the source of data are among the factors states need to consider. The steering committee decided to include Medicare, Medicaid, and commercial market spending, which represents the majority of health care expenditures in the state. The steering committee also opted to include spending by the Veterans Health Administration on state residents and the state's correctional health system spending. States seeking to obtain reliable and complete data on the self-insured commercial market will need to request it from payers. In Rhode Island, the self-insured population represented 42% of the commercially insured market in 2019.[8]

Table 1. Benchmarking Options: Economic Growth versus Consumer Finance

Indicator	Implications of selecting indicator as a benchmark
Economic growth	
Gross State Product (GSP)	Establishes that health care spending should not outpace overall state economic growth.
Consumer finance	
Household Income	Establishes that health care spending should not grow more than household income, a more consumer-centric concept than GSP.
Consumer Price Index (CPI) All Items	Establishes that health care spending growth should not exceed growth in other consumer costs, tying health care spending growth to price changes only.
CPI Less Food and Energy	Establishes that health care spending growth should not exceed growth in other consumer costs, removing historically volatile food and energy price changes.
CPI Medical Care	More generous to health care payers and providers than other CPI measure options, recognizing that, historically, health care cost growth has greatly exceeded All Items CPI.

d. Cost growth target authority

The steering committee established a multi-year cost growth target through a compact signed by all committee members.[9] The target was subsequently codified by executive order,[10] which also directed executive branch agencies to take necessary steps to implement and support the cost growth target program. Rhode Island's path — an executive order following a voluntary compact — is unique among states that have pursued a cost growth target and the direct result of stakeholder convening, cooperation, and compromise. The steering committee considered different authorities for the cost growth target as shown in Table 2.

Steering committee members voiced different opinions on which approach to pursue. The co-chairs initially favored an executive order, but other members strongly preferred a compact. They reasoned that it would signal to the public the health care industry's cooperation to reduce cost growth and it would reduce the role of government. Committee members expressed concern about the legislative approach, noting that it would be difficult to pass legislation without evidence that a target is effective in achieving its goals. Many members indicated that future legislation might be a viable option once the state had experience and results from the target. In the end, the steering committee agreed to a

Table 2. Approaches to Authorizing a Cost Growth Target

Approach	Advantages and Disadvantages
1. Executive Order	An executive order can be executed quickly relative to other approaches, for example, a statute. In Rhode Island, the executive order sustained the momentum of the cost growth target development and allowed for almost immediate implementation. However, executive orders are vulnerable to changes in administrations as priorities and policies may shift. They are also limited in their scope. For example, an executive order alone does not provide funding to support program design and operations.
2. Statute	A statute establishes a cost growth target in law, making it more difficult to overturn or amend compared to an executive order. Yet the legislative negotiation process can be lengthy, with a positive outcome uncertain, and it can result in changes to the original policy intent.
3. Regulation (without new legislation)	New regulations directing the implementation of a cost growth target can be executed relatively quickly, compared to legislative action. However, this approach requires that an agency have existing statutory authority and state funding to proceed with program design and operations.
4. Voluntary Compact	A compact entered into voluntarily creates engagement and buy-in from stakeholders. Like an executive order, it is vulnerable to shifting priorities, and without a mechanism for accountability, it may not motivate widespread change. Other strategy options can compel action in ways a compact does not. A compact also does not provide funding for program support.

> **A shared commitment to transparency regarding cost performance of systems, payers, and larger physician groups is a distinguishing characteristic of this initiative that speaks to the level of accountability that participants have been willing to embrace.**
>
> **G. Alan (Al) Kurose, President and CEO of Coastal Medical, Cost Trends Project Steering Committee Co-Chair**

hybrid approach whereby the cost growth target parameters would be established in a compact signed by the members of the steering committee in conjunction with an executive order, which references the compact and its terms. Because of Governor Raimondo's role in initiating the planning process, she wanted to make a public statement in support of the cost growth target. The governor also wished to apply the power of her office and the resources of state government to support the initiative.

The status of the steering committee as an advisory body to the state, its express charge to support development of a cost growth target, and the representation of large health care system leaders, health insurers, smaller provider organizations, and business and consumer advocate members on the committee were all critical factors for successfully translating the concept of a cost growth target into policy.

e. Accountability for performance relative to the target

To bolster the potential impact of a cost growth target, states should incorporate mechanisms to encourage action by payers and providers to curb costs and enforce performance relative to the target. Those actions can take different forms. One approach is to hold annual cost trends meetings (as in Massachusetts) and require health plans and large providers to report on cost performance. Another option is requiring payers or providers to implement performance improvement plans if the target is not met. Finally, states can take more aggressive action by using their regulatory and purchasing authority. Examples of this approach include influencing insurer premiums, provider rates, state contract awards, or provider mergers, acquisitions, or expansions, or levying fines.

The Cost Trends Project steering committee endorsed a strategy of publicly reporting payer and provider performance by entity name.[11] Reporting of first year (2019) performance will occur in early 2021, and a public meeting to review and discuss findings will follow. This transparency about performance is intended to hold health care entities accountable for curbing costs while providing valuable information about cost drivers to the public to inform targeted interventions.

Neither the compact nor the executive order, by design, incorporates additional accountability mechanisms, such as the examples cited above. Omitting such mechanisms was a factor in garnering payer and provider support for the initiative.

Analyzing Performance against the Cost Growth Target: Early Insights and Lessons

Once a cost growth target is established, it is necessary to assess performance relative to the target. This analysis is customarily conducted using aggregate data reported by payers, rather than a state's all-payer claims database (APCD) data. Like most state APCDs, Rhode Island's APCD, HealthFacts RI, does not contain most commercial self-insured claims payments, nor does it capture non-claims provider payments or pharmacy rebates. This data analysis is distinct from evaluating cost growth and identifying cost growth drivers, which *do* use the APCD. (See Figure 2.)

Figure 2. Purpose of Data Sources for Rhode Island's Cost Trends Project

Payer-Reported Aggregate Data

Primary purpose: Assess performance against the cost growth target

Payer-reported data are provided in aggregate and are limited in detail but do represent all health care spending in the state (including spending in self-insured employer benefit programs).

How much did spending increase or decrease from one year to the next?

APCD Analyzed Data

Primary purpose: Identify underlying cost and cost growth drivers

APCD data are more detailed than payer-reported aggregate data. Claims-level analyses can be performed. While not all state spending data are included, there is more than enough information to understand underlying trends.

What is driving overall cost and cost trends? Where are opportunities?

The Cost Trends Project staff developed payer data specifications for reporting performance against the target and prepared an implementation manual containing technical guidance to assist entities with reporting. Specifications and technical guidance articulated the types of claims and non-claims spending for payers to report and the method for attributing spending to members, primary care providers, and commercial and Medicaid accountable care organizations (ACOs). The state performed an initial analysis of 2017 and 2018 spending using data collected from the Centers for Medicare and Medicaid Services (CMS), Rhode Island Medicaid, and the major commercial, Medicaid managed care, and Medicare Advantage insurers in the state. The state then publicly reported state and market-level spending in the summer of 2020. This process revealed that some payers had difficulty interpreting the data specifications, which resulted in inaccurate data submission. Thus, the state developed a set of procedures for data validation for breaking down spending by service and on a per-member-per-month basis to guide future reporting. In the fall of 2020, OHIC collected revised 2018 data and new 2019 data. The state intends to publicly report performance at the insurer and large provider entity level in early 2021.

Key Takeaways and Insights: There are several lessons learned from Rhode Island's experience collecting data and analyzing total medical expenditure data, including:

Reporting guidance: There is value in publishing an instruction manual that describes how the state will calculate performance relative to the target. The manual should include specific details about data requests of insurers. Those reporting guidelines facilitate more accurate and efficient data submission, but states should be prepared that it will take time for payers to adapt their data reporting processes to respond.

Communication with insurers: Initiating conversations early with insurers about the data needed to assess performance and the collection process ensures a mutual understanding of data requests and open lines of communication to discuss data integrity concerns. States should also review findings with payers in advance of public reporting to allow for a final quality check and discussion of any data concerns.

Process to validate data: Developing a validation process to identify potential inconsistent reporting promotes data integrity. In Rhode Island, *completeness checks* were performed to ensure that there were no obvious errors or omissions in the submitted data. An example of an error is if a payer reports a claims runout period that is different than the specifications. An omission example is when a payer does not submit data for all relevant lines of business. *Reasonableness checks* were performed to ensure that data seemed appropriate when compared to other sources and at face value. For example, member enrollment reported

by the payers should be similar to enrollment reported by CMS for Medicare Advantage patients.

Data-Driven Actions to Address Cost Drivers and Spending Growth

Stakeholder input prior to the launch of the Cost Trends Project included recommendations that the state rigorously analyze drivers of costs and cost growth. This would enable the state to explore factors contributing to health care spending growth and then direct action to address primary cost drivers. Setting a cost growth target allows states to measure spending relative to an established benchmark. The measurement of spending alone, relative to a target, does not show what is driving spending growth. Analyses must be done to identify specific categories of high spending (e.g., pharmacy spending) and drivers of growth to identify opportunities for targeted interventions to reduce growth.

The state partnered with the Brown University School of Public Health for expertise to conduct a thorough analysis of claims data and assess the feasibility of using HealthFacts RI to identify cost trends and cost growth drivers and to deconstruct total medical expenditures by volume and price. The assessment showed HealthFacts RI to be a viable data source for analyses related to drivers of cost, drivers of cost trends, and related analyses that could support cost growth reductions and quality improvement. This viability is despite the absence of most self-insured and non-claims data. While greater self-insured employer participation would make HealthFacts RI a more robust data resource, there are enough data to understand the underpinnings of most health care spending in the state.

Prior to the Cost Trends Project, the state's APCD had limited use and underdeveloped quality control mechanisms. Brown University's robust analysis of the APCD uncovered data integrity issues that required investigation and correction.[12]

With confidence that the APCD could support robust data analyses after data integrity issues were addressed, the Cost Trends Project steering committee began discussing how to leverage HealthFacts RI to enhance the value of health care in Rhode Island. Specifically, the Cost Trends Project sought to design and produce reports from the APCD to inform and motivate improved health care system performance. This is termed the "data use strategy."[13] Consistent with the cost growth target development, the state engaged key stakeholders and the public in the development of a data use strategy. The Cost Trends Project hosted a data use conference to bring together officials from other states and organizations to share their data use strategies to facilitate learning. During the conference, steering committee members and other invited members of the public talked with national experts about opportunities for Rhode Island to maximize use of its APCD. Following the conference, the Cost Trends Project held two focus groups to gather

The Cost Trends Project provides an invaluable opportunity to analyze the root causes of health care spending growth in our state and utilize that data to change behaviors and take steps to reduce the costs of quality care in our state. The data analyses from the Cost Trends Project will be instrumental in arming our health care leaders with the tools needed to collaboratively transform our health care system into one characterized by maintenance of both high quality and affordability.

Marie Ganim, former Rhode Island Health Insurance Commissioner, former Cost Trends Project Steering Committee Co-Chair

input on meaningful analyses of the APCD, leveraged the steering committee meetings to structure ongoing conversation about a data use strategy, and hosted an open meeting to publicly present draft recommendations for leveraging HealthFacts RI.

Strategic Analyses Using Rhode Island's APCD
1. Cost drivers, including: a. Utilization variation b. Price and cost variation c. Low-value services d. Potentially preventable services
2. Cost growth drivers
3. Population demographics, including social determinants of health
4. Quality of care

Key Takeaways and Insights: Several key themes that emerged in the process of developing a data use strategy offer an important roadmap as the state pursues institutionalized analyses and reporting practices. They include:

Stakeholder engagement is at the heart of leveraging APCD analyses to promote health system change. Stakeholder involvement from a project's inception is essential to building trust and producing actionable results. Community involvement in communicating and framing results about cost in the context of quality; ensuring data are accessible to stakeholders, noting a tension with potentially exposing market-sensitive information; and ensuring diverse voices are also key considerations and should be addressed in the development of analyses and reporting.

Producing **actionable results** is equally important. Rhode Island's initial focus is producing reports for providers and the public as the primary audiences. To ensure reports are meaningful and actionable, it is important to involve provider organization representatives, state policymakers, and other intended report users, including employer purchasers, to ensure reports are effective for routine publication.

Sustainability planning is of the utmost importance to ensure the implementation of the data use strategy and ongoing analyses of the APCD.

Finally, states with APCDs, particularly those without robust analytics or collection processes, should not wait until performance is ready to be assessed before performing a **thorough examination of their claims data**. This early analysis of the APCD may reveal where data are missing or incomplete.

In late 2020, the state began analyzing three primary cost drivers: pharmacy spending, outpatient hospital spending, and specialist spending. Analysis of pharmacy spending led to the identification of potential strategies to address price growth, and steering committee recommendations to the state on how it should proceed. Rhode Island anticipates that these analyses will identify opportunities for improved clinical care and is planning to convene a provider collaborative in 2021 to focus on the first prioritized opportunity related to outpatient hospital or specialist spending.

Leveraging state APCDs to conduct sophisticated cost analysis, and then translating those analyses to strategic action on cost growth, constitutes both a significant opportunity and a challenge.

Sustaining Cost Growth Target Work

The executive order initiating the cost growth target does not (and cannot) appropriate funds for ongoing implementation or sustainability. Although grant funding from the Peterson Center on Healthcare provided the necessary start-up investment to develop the target and support data analysis, the state will need to determine an ongoing financing mechanism to sustain the work. The governor's FY22 budget will propose an assessment (i.e., a tax) on commercial insurers, Medicaid, and self-funded businesses to provide sustaining funding to support the program and to codify the work in statute. In addition, the state has sought local foundation funding to support aspects of program operations.

Key Takeaway and Insight: States that have operationalized a target through voluntary compact and/or executive order may often have more difficulty finding funding to sustain the work than those with enabling legislation.

Cost Growth Targets and Health Care Reform

A state health care cost growth target is a powerful way to advance health care cost containment. Targets for growth in total health care spending can help states

gain a clearer picture of spending and support targeted policies and interventions to curb spending and improve system performance.

Yet targets alone are unlikely to contain cost growth, improve health care system performance, and better population health. Rhode Island and its participating stakeholders are well aware of this. As a result, the state has undertaken multiple other initiatives, including a Medicaid accountable care program that involves shared savings and risk contracting with large provider entities, regulation of commercial insurer hospital rate increases, targeted increases for accountable care organization budgets, greater adoption of alternative payment models, and support for broad-scale primary care transformation.

The Cost Trends Project complements these and other initiatives, largely by identifying the underlying, core drivers of cost and arming the state, providers, and payers with information to take meaningful action. Investments in analytics extend beyond the cost growth target, yielding additional value. Lastly, there is the long-lasting impact of stakeholder collaboration to address systemic issues, a benefit that the state hopes will pay dividends as it faces other challenges.

Rhode Island's cost growth target development and design were specific to the state, its culture, and its environment. Other states will need to customize their process and design, cognizant of the extent of state personnel and data resources to support the work, stakeholder perspectives on cost containment as a public good, and the extent to which there is a proclivity for collaborative effort in the state. Despite these state-specific considerations, the policy and technical questions any state considers will likely be similar to those Rhode Island faced. Just as Rhode Island learned from Massachusetts, other states will now benefit from Rhode Island as they design and implement their own cost growth initiatives.

This work was funded by the Peterson Center on Healthcare.

Notes

1. Between 2015 and 2017 the per capita growth rate of fully insured commercial allowed spending in Rhode Island was between 5.0% and 5.5%, as calculated from the Office of the Health Insurance Commissioner's rate templates. The average annual rate of gross state product between 2015 and 2017 was 2.3%, as calculated from data supplied by the U.S. Bureau of Economic Analysis.
2. National health care expenditures (NHEs) in the United States continue to grow at rates outpacing the broader economy: Inflation- and population-adjusted NHEs have increased 1.6% faster than the gross domestic product (GDP) between 1990 and 2018. US national health expenditure growth as a share of GDP far outpaces that of comparable nations in the Organization for Economic Cooperation and Development (17.2% versus 8.9%). Cahan EM, Kocher B, Bohn R. Why isn't innovation helping reduce health care costs? *Health Affairs* Blog, June 4, 2020. https://www.healthaffairs.org/do/10.1377/hblog20200602.168241/full/. Accessed January 21, 2021.
3. Pearson E, Frakt A. Health care cost growth benchmarks in 5 states. *JAMA*. 2020;324(6):537–538. doi:10.1001/jama.2020.12437
4. Rhode Island's health care cost growth target is 3.2% per capita for 2019–2022. This is equal to the rate of long-term projected state economic growth.
5. Press release from the office of U.S. Senator Sheldon Whitehouse of Rhode Island. RI health care leaders send reform recommendations to Raimondo and General Assembly leaders. December 23, 2014. https://www.whitehouse.senate.gov/news/release/ri-health-care-leaders-send-reform-recommendations-to-raimondo-and-general-assembly-leaders. Accessed January 21, 2021.
6. The Oregon legislature through Senate Bill 889 (2019 Laws) has established the Sustainable Health Care Cost Growth Target Program within the Oregon Health Authority. https://olis.leg.state.or.us/liz/2019R1/Downloads/MeasureDocument/SB889/Enrolled. Accessed January 21, 2021.
7. Rubinkam, M. Wolf seeks commission to rein in health care spending. Associated Press, October 2, 2020. https://apnews.com/article/pennsylvania-health-care-costs-tom-wolf-df2bbc0f5e11a25759f0ed3f1e41078b. Accessed November 16, 2020.
8. Share of Private-Sector Enrollees Enrolled in Self-Insured Plans. Kaiser Family Foundation State Health Facts. 2019. https://www.kff.org/other/state-indicator/share-of-private-sector-enrollees-enrolled-in-self-insured-plans-2018/?currentTimeframe=0&selectedRows=%7B%22states%22. Accessed January 21, 2021.
9. State of Rhode Island: Office of the Health Insurance Commissioner. December 19, 2018. http://www.ohic.ri.gov/ohic-reformandpolicy-costtrends.php. Accessed September 20, 2020.
10. Rhode Island Executive Order No. 19-03. February 6, 2019. https://governor.ri.gov/newsroom/orders/. Accessed December 3, 2020.
11. The steering committee established a minimum population size of 5,000 attributed lives (Medicare) and 10,000 attributed lives (commercial and Medicaid) for public reporting of performance.
12. This work was supported by a committed team of researchers and liaisons with the state's APCD vendor and the state. This support helped the state work through challenges encountered throughout the process, including not anticipating the amount of time it would take to transfer data using the APCD vendor's business practices. There was also a learning curve to fully understand the state-specific APCD features and operational capabilities. The Cost Trends Project leveraged the state's APCD in a way it had not been used before, and this first significant analysis of the APCD uncovered the need for data scrubbing and revealed that the time to access data was longer than anticipated.
13. State of Rhode Island: Office of the Health Insurance Commissioner. May 17, 2019. http://www.ohic.ri.gov/ohic-reformandpolicy-costtrends.php. Accessed September 20, 2020.

AUTHORS

Erin Taylor, MPH, is a senior consultant at Bailit Health with experience in public health, health care policy analysis, and payment and delivery system reform. Ms. Taylor has researched and evaluated value-based payment strategies for individuals with complex care needs, including seniors and individuals with disabilities enrolled in managed care. Ms. Taylor supported the process for developing the Rhode Island Cost Trends Project data use strategy, including analyzing how states use their all-payer claims databases to improve health care system performance. Ms. Taylor earned a Bachelor of Science degree from the University of Florida and a Master of Public Health degree with a concentration in health law, bioethics, and human rights from Boston University.

Michael Bailit, MBA, is founder and president of Bailit Health. Mr. Bailit´s professional interests focus on how purchasers and regulators can influence health care markets to operate as effectively and efficiently as possible. He serves as lead consultant to Rhode Island for its Cost Trends Project and has worked with an array of state agencies and employer purchasing coalitions in more than 30 states. Mr. Bailit has worked with several state clients on cost growth target development and payment and delivery system reform, including accountable care organizations, medical home and episode–based payment strategy design and implementation, performance measurement, value–based purchasing, and multi–stakeholder change process guidance and facilitation. Mr. Bailit earned a Bachelor of Arts degree from Wesleyan University and an MBA from the Kellogg School of Management at Northwestern University.

Megan Burns, MPP, is a senior consultant at Bailit Health with a decade of state health care policy consulting experience and has developed expertise in state health care cost growth benchmark policies. Ms. Burns has helped Rhode Island, Delaware, Oregon, and Connecticut develop their health care cost growth target programs. Ms. Burns also has expertise in payment reform, value-based purchasing, regulatory review, and behavioral health integration strategies. She has performed both applied and research work for states, health plans, providers, and non-government clients. Ms. Burns earned a Bachelor of Arts degree in political science from the State University of New York at Cortland and a Master of Public Policy degree from the Terry Sanford Institute at Duke University.

Justine Zayhowski, MPP, is a consultant at Bailit Health who supports state work to establish cost growth and quality targets, to enhance performance measurement, and to maintain multi-payer aligned measure sets. Ms. Zayhowski has provided project management support and analyzes performance against the cost growth target for the Rhode Island Cost Trends Project. She assisted in the development of Delaware's quality benchmarks for its cost growth benchmark program. Ms. Zayhowski also supports state work to enhance performance measurement and to maintain multi-payer aligned measure sets. She earned a bachelor's degree in Health: Science, Society, and Policy from Brandeis University and a Master of Public Policy degree from the Heller School at Brandeis University.

About the Milbank Memorial Fund

The Milbank Memorial Fund is an endowed operating foundation that works to improve the health of populations by connecting leaders and decision makers with the best available evidence and experience. Founded in 1905, the Fund engages in nonpartisan analysis, collaboration, and communication on significant issues in health policy. It does this work by publishing high-quality, evidence-based reports, books, and *The Milbank Quarterly*, a peer-reviewed journal of population health and health policy; convening state health policy decision makers on issues they identify as important to population health; and building communities of health policymakers to enhance their effectiveness.

About the Peterson Center on Healthcare

The Peterson Center on Healthcare is a non-profit organization dedicated to making higher quality, more affordable healthcare a reality for all Americans. The organization is working to transform U.S. healthcare into a high-performance system by finding innovative solutions that improve quality and lower costs, and accelerating their adoption on a national scale. Established by the Peter G. Peterson Foundation, the Center collaborates with stakeholders across the healthcare system and engages in grant-making, partnerships, and research. For more information, visit petersonhealthcare.org.

Milbank Memorial Fund
645 Madison Avenue
New York, NY 10022
www.milbank.org

Peterson-Milbank
Program for Sustainable
Health Care Costs