Findings from an Evaluation of the OHIC Affordability Standards

Rhode Island Health Insurance Advisory Council Meeting
June 25, 2013

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Agenda

1. Evaluation Approach Overview
2. Overall Assessment
3. Discussion of Individual Standards
   - Stakeholders' perceptions
   - Results of data analysis
   - Bailit's assessment

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Quick Refresher:
The Affordability Standards

1. **Primary Care Spending**: Expand the requirement to increase primary care spending by 1% per year; increase the percentage of funding directed to non-fee-for-service activities by 5% per year

2. **Medical Home Support**: Spread the adoption of the patient-centered medical home

3. **Support Current*care*** : Financially support Current*care*, the Rhode Island health information exchange

4. **Reform hospital payment arrangements** via six hospital contracting conditions

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Quick Refresher: How The Assessment Was Conducted

- Addressed three considerations for each standard:
  1. Insurer compliance
  2. Value of the standard, i.e., does it represent an efficacious policy to achieve OHIC's desired aims?
  3. Recommendations for modifications (if any)
- Interviewed key stakeholder representatives: providers (physicians and hospitals), payers and employers
- Collected payer claims utilization data on measures potentially impacted by Affordability Standards
  - HEDIS measures covering access
  - Utilization data
- Reviewed payers' hospital contracts

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Bailit's Overall Assessment

1. The Standards have broad-based support and promote good public policy to lower costs and promote primary care services.
2. The State's activities created momentum for real change
3. Having the state as a partner was essential to making change happen "on the ground."
4. Standards appear to have been effective in:
   a. promoting Medical Home transformation, and
   b. slowing rate of hospital cost increases.
5. The Standards have been successful in changing payer-hospital contracting dynamics and in advancing outcome-oriented quality programs in hospitals.

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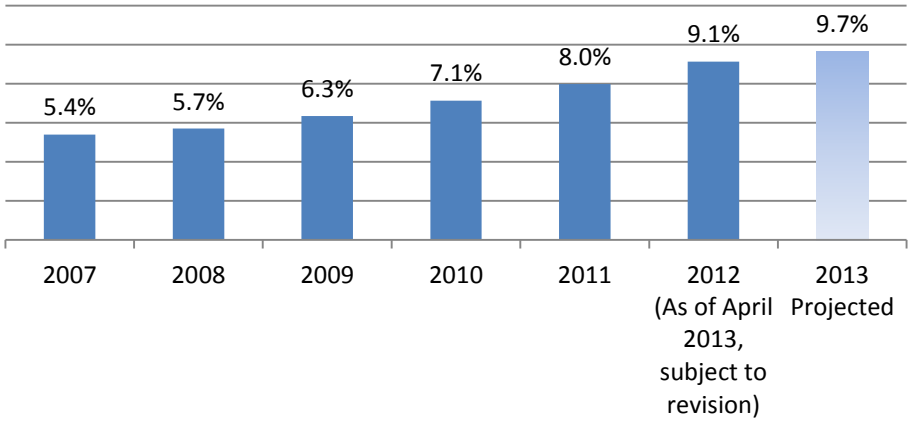
Standard 1: Primary Care Spend Standard

- **Goal:** expand and improve primary care infrastructure by increasing the % of spending on primary care
- **Finding:** achievement of 1% Primary Care Spend target
  - Increases in primary care spending started prior to the Standard's implementation in 2010, but have accelerated since 2011.
  - Share of spending on primary care increased from 5.4% in 2007 to 9.1% in 2012 - an increase of 69%.

Primary Care Spending in Aggregate as Percent of Total Medical Spending, 2007 - 2013



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Achievement of 1% Primary Care Spend Requirement (cont'd)

- Since total spending on medical care recently dropped in RI and this could have produced the observed increased % of spending on primary care, Bailit also looked at changes in absolute dollars spent by the insurers.
  - Beginning in 2009, both BCBSRI and Tufts have increased the absolute dollars in primary care spend at rates that exceed 1% annually.
  - United's primary care spend dollars increased between 2010 and 2012 to meet the 1% target. In 2013, United projects a 1% increase in % of spend on primary care by projecting a 10% decrease in total medical spending
    - This 10% decrease is inconsistent with national forecasts of a 7.5% increase in total medical spending.

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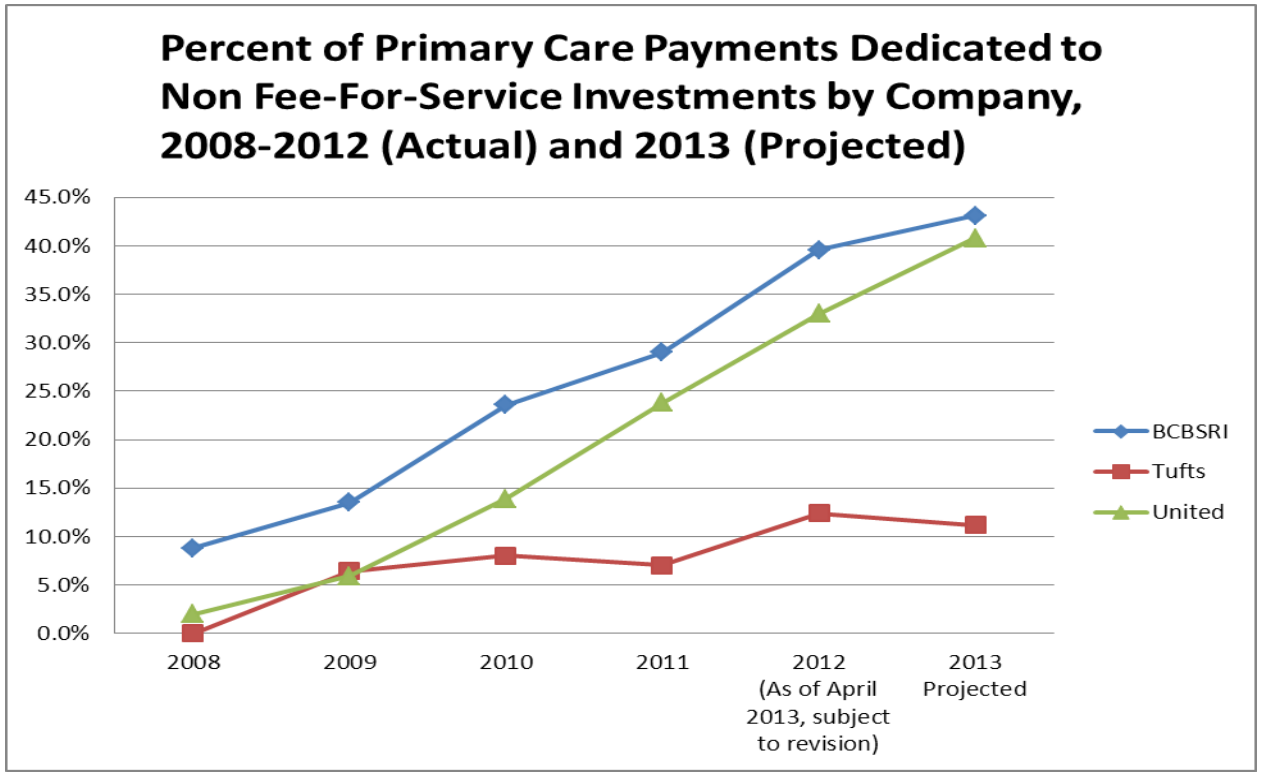
Achievement of 30% Spending on Other-Than-FFS Requirement

- BCBSRI and United achieved the goal of at least 30% of Primary Care Spend on other than FFS. Tufts, not subject to the standard, did not.



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Stakeholders' Perception of Primary Care Spend

- Payers used targeted approach to distribute $s
  - BCBSRI estimates 35% of PCPs received funding
  - United estimates 59% of PCPs received funding
- Providers believe that PCPs not participating in CSI did not benefit from the Primary Care Spend Standard
- PCPs receiving funding generally used it to build infrastructure, rather than increase PCP reimbursement.
  - One practice did use funds to reimburse PCPs for activities not otherwise reimbursable (e.g., meet with care team)

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Impact of Primary Care Spend on Practices Receiving Support

- Improve organizational and financial stability
  - Interviewees saw medical home transformation as essential to survive in the new environment focused on quality and cost effectiveness and therefore key to future viability.
  - Others saw support as an “important piece of the funding puzzle” to build necessary infrastructure
- Improve access to primary care
  - Physicians did not view the added funding as improving the level of access to care.
- Retain non-physician staff
  - Building infrastructure created a more exciting place to work and thereby indirectly improved staff retention

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Impact of Primary Care Spend on Practices Receiving Support (cont'd)

- Retain physicians
  - None of physicians interviewed believe the primary care spend standard increased physician retention
    - Hard to compete with hospitalist salaries that can exceed that of an experienced PCP
    - Total compensation appears to be higher in surrounding states
  - Several believed that creating a medical home made practice more enjoyable and a more desirable place to practice for physicians.

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Impact on Utilization

- The only utilization that appeared to be possibly impacted by the Affordability Standards was ED utilization
  - ED visits/1000 declined in 2011 at a time when regional average was increasing.
    - Could be due to recession
    - Correlation will become clearer over time
  - Incidence of ED visits for ambulatory care-sensitive conditions showed a very slight, but noticeable decrease in 2010 that appears to be maintained through 3 quarters of 2012
    - Could be due to recession
    - Correlation will become clearer over time

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Bailit's Assessment of Standard 1

- Through 2012, payers have met the requirement to increase Primary Care Spend by 1% annually and to direct a specified proportion to non-FFS payments
- Primary Care Spend funds have been a vital source of funding to build primary care practice infrastructure to support practice transformation
- Benefits have gone to a targeted group of primary care providers participating in CSI and payer-specific medical home initiatives, so impact has been limited
- Impact on cost and utilization will not likely be realized until more primary care practices have transformed into medical homes

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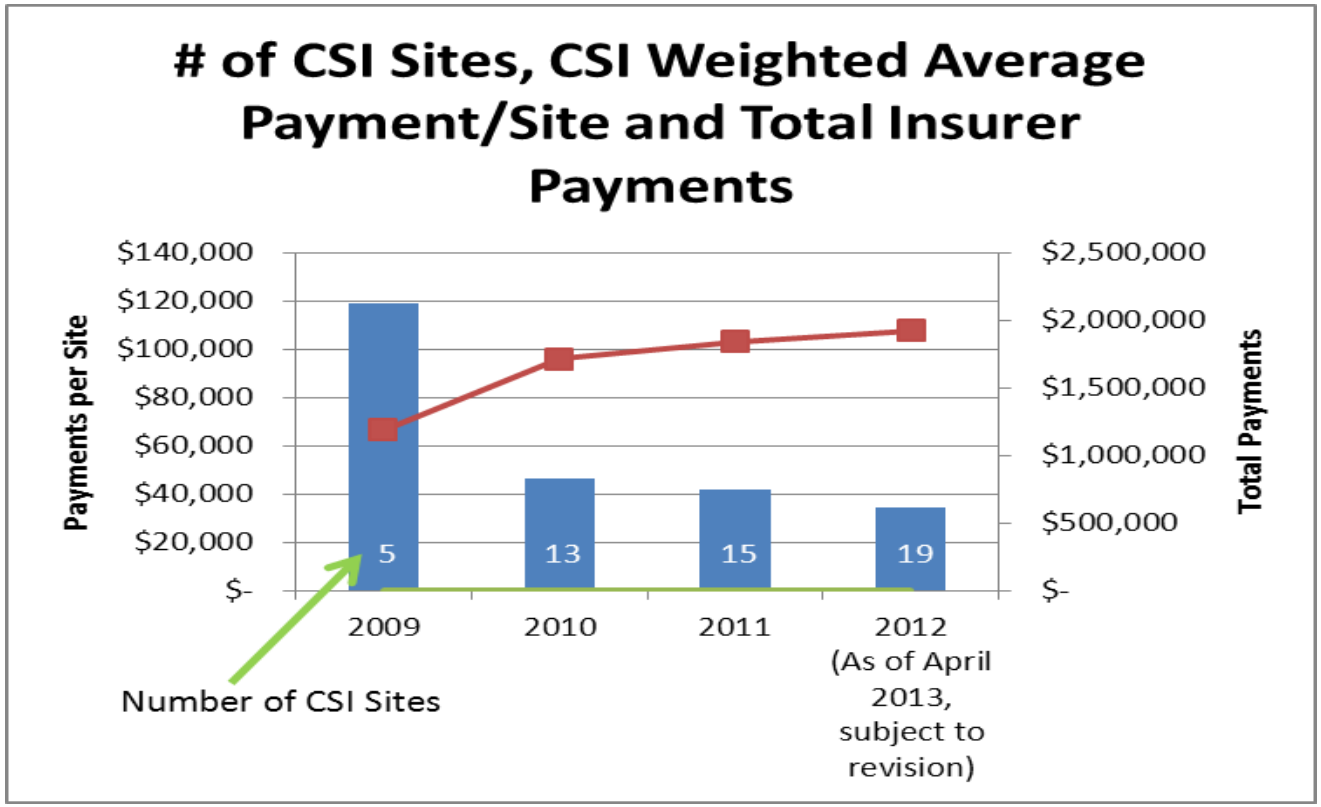
Standard 2: Promote Medical Homes

- Three major payers have provided on-going support to CSI practices and the number of sites has grown



Promote Medical Homes (cont'd)

- BCBSRI and United have pursued their own medical home initiatives with non-CSI practices
- Based on data submitted by payers, it is estimated that 40% of PCPs in Rhode Island are associated with practices in some state of medical home transformation
- Significant change in practice dynamics may become evident in plan-wide utilization and cost data when a sufficient number of practices have transformed

Bailit's Assessment of Standard 2 (Medical Homes)

- Standard considered by all stakeholders to be a "game changer" in RI.
  - Created a common structure that unified program for providers
  - BCBSRI and United have their own medical home initiatives that follow CSI structure and are available to non-CSI practices
  - Allowed Tufts as a new payer to quickly integrate into the program
- To reach the "tipping point" and achieve desired transformation throughout RI, support for medical homes must be significantly expanded to additional practices.

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Standard 3: CurrentCare

- OHIC changed standard from requiring payers to provide EMR incentives to requiring payers to support the state's health information exchange (CurrentCare)
- CurrentCare is a statewide Health Information Exchange that will enable participants to share clinical data among providers and with patients
- Although payer support for CurrentCare does not directly benefit primary care, having an HIE should ultimately improve quality of care by sharing clinical information among affiliated providers

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Standard 4: Hospital Contracting Requirements

- The hospital contracting standard includes six discrete requirements
  - **Units of Service:** Move to payment methodologies that promote efficient use of services.
  - **Rate of Increase:** Limit rate increases to the CMS National Prospective Payment System Hospital Input Price Index
  - **Quality Incentives:** Provide hospitals with opportunities to increase total revenues through achieving quality goals.
  - **Administrative Simplification:** Simplify administrative processes between payers and providers.
  - **Care Coordination:** Require implementation of nine best practices that improve quality of inpatient discharges and transitions of care.
  - **Transparency:** Permit disclosure of the terms of hospital contracting requirements.

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Units of Service Requirement

- Use of DRGs (inpatient) and APGs (outpatient) methodologies are taking hold in Rhode Island
  - BCBSRI is moving to DRGs and APGs more aggressively than is United
  - Tufts is moving its largest hospitals to DRGs and APGs
- Payers are moving to payment methodologies that promote both efficiency and quality of care, principally shared savings programs with large provider groups
  - United is further along in negotiating and administering global payment contracts with Lifespan and Coastal Medical
  - BCBSRI is committed to contracting with Care New England under a global payment arrangement

Units of Service Requirement (cont'd)

- Lifespan appears to be further invested in alternative payment arrangements than other providers in RI
- Mental health facilities are less likely than acute care hospitals to be reimbursed under alternative payment methodologies.
- BCBSRI and Tufts data combined indicate that approximately 20% of payments are made under an "alternative payment methodology"
  - 18% under FFS plus a pay-for-performance program
  - 1% under capitated payments (provider upside and downside risk)
  - 1% under shared savings (upside risk only)provider

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Bailit's Assessment of the Units of Service Requirement

- Payment reform, while taking hold, is still modest.
  - Predominantly DRGs and APGs, both of which have been used nationally by Medicare for a long time (DRGs since 1983 and APGs since 2000)
  - Other are using pay-for-performance programs, which are not very effective in fundamentally changing delivery system design and function
  - Risk-sharing agreements are new to Rhode Island and currently only include upside risk

Rate of Increase Requirement

- With rare exception, all contracts limited rate increases to the CMS index.
- Exceptions related generally to financially distressed hospitals
- Cap has significantly changed the negotiating dynamics between payers and hospitals

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Quality Incentive Requirement

- All but one audited contract included quality incentives.
  - For older contracts requiring at least a 2% incentive, two BCBSRI contracts and two Tufts HP contracts did not meet the 2% floor
  - For contracts signed after October 2012 which did not need to meet a minimum 2% requirement, there was a range of quality incentives, some above and some below the old 2% floor
  - United and BCBSRI paid quality incentives as a percentage increase in payment rates and usually prospectively, retrieving payments if quality goals were not met
- Two payers believe that these requirements have resulted in a culture shift within hospitals
  - Moving towards outcome measures (e.g., reduction in infection rates), rather than documentation (e.g., QI policy in writing) or process (e.g., monthly QI committee meeting) requirements

Bailit's Assessment of the Quality Incentive Requirement

- Implementation of the standard has produced two major concerns:
  1. Quality incentives can be used to circumvent the rate-of-increase cap by treating quality payments as part of a rate increase.
  2. Including quality incentives within rate increases is more inflationary than making lump sum payments, because future rate increases include the quality portion of the rate increase.
- Other than feedback from payers, we do not know how effective the quality incentives have been in prompting hospitals to achieve performance targets

Other Hospital Contracting Requirements

- Administrative Simplification
  - Issues are systemic and better resolved by involving all stakeholders
  - Administrative Simplification Taskforce created by legislature will report findings later this summer
- Care Coordination
  - Only BCBSRI consistently included care coordination requirements in its contracts
  - Others created quality incentives to implement Safe Transitions Program led by Healthcentric Advisors
- Transparency
  - BCBSRI and United included transparency language in all but one contract
  - Tufts included required language in only a few of its contracts

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Self-Insured Accounts' Support of Affordability Standards

- Between 2005 and 2012, the commercial market percentage of fully insured decreased from 66% to 57% and self-insured increased from 34% to 43%.
- Self-insured accounts benefit from hospital standards, medical home promotion & CurrentCare.
- United is renegotiating self-insured accounts to cover payments outside standard fee-for-service payments, such as PMPM CSI payments and estimates more than half of its Rhode Island contracts have been changed.
- Tufts reported no plans to renegotiate its self-insured account contracts.
- BCBSRI has not yet responded to inquiries.

Unintended Consequences

- One payer reported several hospitals were unwilling to negotiate contracts longer than two years in the hope that the OHIC rate-of-increase cap will not be long-lived
- The three largest insurers expressed the concern that providers expect to receive payments without having to meet specific levels of performance
  - Believes this attitude will undermine the effectiveness of payer funding to incentivize innovation

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Conclusion

- The Affordability Standards have had a profound impact on health care in Rhode Island by:
  - promoting primary care transformation
  - changing the dynamics between payers and hospitals to increasingly emphasize quality and efficiency
  - creating a sense of mutual benefit and cooperation among payers and between payers and providers
- The state can address consumer affordability interests and help promote and sustain broad-scale change to that end.
- We will present recommendations for Affordability Standards modifications during an autumn HIAC meeting.

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Discussion Questions

- Do you agree with these findings?
- What impact do you think the Affordability Standards have had on:
  - commercial health insurance affordability?
  - the organization and delivery of health care in Rhode Island?

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