Summary of Rhode Island's Health Insurance Affordability Standards and Recommended Modifications

Affordability Standard	Recommendations
Affordability Standard #1: Primary Care Spend: • expand percentage of total medical payments made to primary care by 1% per year; • increase funding directed to non-fee-for-service activities by 5 percentage points per year	1.Retain requirements that plans meet a primary care spend target annually
	2.Continue to increase the percentage of required funding for non-FFS activities
	3.Update initial benchmark study to determine appropriate target for primary care spend and non-FFS target
	4.Expand definition of non-FFS activities to recognize changing marketplace to allow support for: • programs that build risk-bearing entity infrastructure • programs that promote physical – behavioral health integration • shared support resources among small, independent practices • implementation of evidence-based, community-based initiatives
	5. Require insurers to reallocate unearned quality incentive funds to other primary care providers that did meet quality standards, targets or requirements.
Affordability Standard #2: Spread the adoption of the PCMH model	1.Retain standards and bring PCMH to scale quickly by one of the following: a. Retain current program structure and quickly expand both CSI and insurer-specific programs b. End CSI and require insurers to quickly expand their specific PCMH programs c. End payer-specific initiatives and use CSI as the exclusive program for PCMH expansion d. Transform CSI into a parameter-setting entity with contracting and program implementation done by the insurers. Set aggressive expansion targets
Affordability Standard #3: Support Current*Care*	1.Retain current requirement and conduct future assessment whether an HIE benefit has been realized
	2.Limit the percentage of non-FFS spending that may be directed to Current*Care* to avoid diminishment of direct PCP support

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<table>
<tr><td rowspan="6">Reform hospital payment arrangements via six hospital contracting conditions
Units of service
Rate of increase
Quality incentives
Administrative Simplification
Care Coordination
Transparency</td><td>2.Add new requirements to promote payment reform:
Require insurers to contract with providers on a population basis to cover a specific percentage of covered lives, increasing annually
Require insurers to include downside risk in population-based contracts for a specific percentage of covered lives
Limit global payment increases to externally calculated economic index
Require payments to include a quality component
Consider governance standards to promote a strong primary care foundation and values the role of PCPs in risk-bearing entities
Collect outcome measures to determine if desired results for the Hospital Contracting/Payment Reform Standard are being realized.</td></tr>
<tr><td>3.Units of Service and Rate of Increase
Apply cap on increases to both quality payments and price increases
Allow hospitals participating in population-based contracts with down-side risk to be exempt from the hospital cap rate</td></tr>
<tr><td>4.Quality Initiative
Retain the current requirement
Require measures to target improving management of patients with chronic conditions and high-risk patients and strengthen coordination among participating providers/across continuum of care
Prohibit inclusion of quality incentives in the base hospital rate
Require quality measures to include measurement of effectiveness of transitions-of-care process
Include a consensus process to measure effectiveness of quality incentives</td></tr>
<tr><td>5.Administrative Simplification: eliminate this requirement</td></tr>
<tr><td>6.Care Coordination: eliminate this requirement</td></tr>
<tr><td>7.Transparency: retain this requirement</td></tr>
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