

Assessment of the  
Rhode Island Office of the Health Insurance  
Commissioner's  
Affordability Standards

*FINAL REPORT*

Bailit Health Purchasing, LLC  
August 2013

## I. Executive Summary

In 2009 the Rhode Island Office of Health Insurance Commissioner (OHIC) established a set of standards designed to slow the growth of health insurance premium costs in Rhode Island by providing additional financial support for primary care providers and promoting health care payment reform.<sup>1</sup> Collectively these standards are referred to as the “Affordability Standards.” This report was commissioned by OHIC to evaluate the Affordability Standards by:

- updating the earlier Affordability Standard assessments;
- evaluating the efficacy of each standard to achieve OHIC’s desired aims, and
- providing recommended modifications to the Affordability Standards based on the evaluation.

The key findings of this report are the following:

- The Affordability Standards are seen as good public policy. Stakeholders see the state’s role as leader and partner as critical in tipping the balance to create momentum for change. They are perceived to be particularly effective in moving medical home transformation forward and in slowing the rate of hospital cost increases.
- Between 2010 and 2012 both Blue Cross and Blue Shield of Rhode Island (“BCBSRI”) and UnitedHealthcare (“United”) have annually met the Standard One requirement to increase primary care spending by 1% annually, and to direct at least 30% of primary care spending in 2012 to non-fee-for-service activities. Tufts Health Plan is not currently required to meet this Standard. BCBSRI is expected to achieve both goals in 2013; however, United’s projected Primary Care Spend percentage increase is based on the questionable assumption that overall medical spending will decline by 10%.
- Generally, funding was used by practices to build practice infrastructure, and not to increase individual provider income. The Primary Care Standard appears to have had a profound impact on primary care practices’ ability to transform. The analysis of utilization data suggests that the practice transformation may be having an impact on reducing emergency department utilization, but not on inpatient utilization or primary care or specialist utilization.
- All insurers are actively supporting the Rhode Island Chronic Care Sustainability Initiative (CSI), as required by Standard Two. Both BCBSRI and United have their own medical home initiatives targeted at practices that are not participating in CSI. This standard is considered by all stakeholders to have been a “game changer” in Rhode Island. CSI unified all insurers behind a single payment and practice redesign model and started stakeholders thinking and talking on a system level.
- Although *CurrentCare* funding does not go directly to primary care providers, OHIC’s decision to shift Standard Three from insurer funding of EHRs to an IT project where insurer funding for infrastructure can have a more significant impact is reasonable. However, it is too early to know the impact of *CurrentCare* on health care delivery and affordability. In 2012 only BCBSRI made payments in support of *CurrentCare* as a portion of its non-fee-for-service Primary Care Spend payments. Beginning in 2013 all

---

<sup>1</sup> Bailit Health Purchasing, LLC, assisted the Rhode Island Health Insurance Commissioner in developing the original Affordability Standards. Bailit drew upon its first-hand knowledge of the intent of the Affordability Standards in developing its assessment of the effectiveness of the Affordability Standards and in developing its recommendations.

insurers will be required to support CurrentCare to meet the non-fee-for-service Primary Care Spend requirement.

- Compliance with Standard Four, Hospital Contracting Standards, varied by standard. The insurers are slowly moving to alternative payment models as required under the Units of Service requirement. All insurer contracts, with rare exceptions for financially struggling hospitals, include limits on rate increases that are consistent with the Rate of Increase requirement. Similarly, all contracts, with a few exceptions, include quality incentives at levels that meet this requirement. Most contracts included the administrative simplification language. Only BCBSRI consistently included care coordination requirements in its contracts. BCBSRI and United included transparency language in all but one contract. Tufts included the required language in only a few of its contracts.
  - Two components of Standard Four, setting an inflation cap and tying quality performance to revenue gains, have had a profound impact on insurer – hospital relationships by providing insurers with leverage to move the hospital’s focus away from guaranteed increases to earned increases. However, the structure of these requirements is such that it is possible to use the quality incentives to circumvent the OHIC goal of limiting hospital rate increases. Moreover, removing the 2% floor on quality incentive payments did not appear to noticeably impact the level of incentives negotiated by the parties, but provides insurers with more flexibility.
  - Payment reform, also a Standard Four requirement, is taking hold in Rhode Island, but the scope and pace of change to date has been modest. The payment methodologies that encourage efficiency that are being most commonly adopted are paying hospitals for inpatient services using Diagnosis-related Groups (DRGs), which have been used by Medicare for decades, and Ambulatory Payment Classifications (APCs), which were implemented by Medicare in 2000. Risk-sharing arrangements, which promote both efficiency and quality, are just starting to be negotiated and implemented by the two hospital systems and are otherwise in place with just one multi-practice primary care organization. Currently, providers have only upside risk, which may limit the pace and extent of delivery system change.
  - Two other Standard Four requirements, promoting administrative simplification and care coordination, appear to have had limited effect. Administrative simplification issues are best addressed collaboratively across all providers and insurers, rather than separately by an insurer and provider because most issues need to be addressed systemically. The care coordination requires hospitals to report to a third party, making it very difficult to determine if the requirement has had any impact on hospital procedures. A representative from Healthcentric Advisors, the Medicare QIO overseeing the care coordination initiative, reported that its staff is working directly with the hospitals to make sure that the implementation is meaningful and effective, and not just a box-checking exercise.
  - The final Standard Four requirement, promoting transparency of Standard Four terms by the state or participating parties, was used by OHIC to publish a hospital rate study. According to insurers, publishing this information has provided lower paid hospitals with comparison rates that they are using to seek higher payment, rather than to promote lower costs through price competition.

Bailit’s key recommendations are the following:

- Extend the Affordability Standards through 2018.
- **Standard One:** Continue requiring insurers to meet Primary Care Spend targets. To determine whether the target needs adjusting, update the benchmarking study. Based on the results, either maintain the current target or make adjustments, as appropriate.

Even if the target is not adjusted, continue to increase the percentage of funding that must be directed towards non-fee-for-service activities annually. To recognize the changing marketplace and enable insurers to meet these goals, include within the type of spending that meets the definition of non-fee-for-service primary care spending support for infrastructure and programs that:

- Give risk-bearing provider groups the ability to effectively assume financial responsibility for managing the care for a defined population of patients, such as developing data informatics capabilities.
- Promote behavioral health – somatic health integration within the primary care practice, (e.g., funding to hire behavioral health specialists, funding the development of a universal care plan or funding the development of software that enables PCPs to locate and communicate with behavioral health providers about patient service needs.)
- Provide shared support that enables small, independent practices to become medical homes. Shared support could include care managers, pharmacists and data analysts.
- Promote the development and implementation of community-based care initiatives, such as evidence-based transitions of care programs developed through CMS' Community Based Advanced Care Management initiative.
- **Standard Two:** Retain this standard and consider three options to rapidly bring medical home transformation to scale:
  - Retain the current program structure and quickly expand both CSI and insurer-specific programs.
  - End CSI and require insurers to quickly expand their specific medical home programs.
  - Transform CSI into a parameter-setting entity with contracting and program implementation done by the insurers. Set aggressive expansion targets.
- **Standard Three:** Retain in its current form for now and assess its impact in the future. Reconsider whether *CurrentCare* should qualify as Primary Care Spend, as it is not direct primary care support. Should the Commissioner choose to continue to consider *CurrentCare* payment as an acceptable non-fee-for-service payment, limit the percentage of non-fee-for-service spending that may be directed to *CurrentCare* to avoid diminishing direct PCP support.
- **Standard Four:** Restructure Standard Four to become a payment reform standard, while retaining several existing requirements. To promote payment reform:
  - require insurers to contract with providers on a population basis to cover a specified percentage of covered lives by year (such as year one - 25%; year two - 50%, and year three - 75%).
  - recognizing the growing evidence that significant transformation only comes with assumption of down-side risk, require insurers to include downside risk in the population-based contracts that cover a specified percentage of covered lives (such as year one - none; year two - 15% and year three - 45%)
  - limit global payment amounts to an externally calculated economic index.

- require that payment include a quality component, such that payments are contingent on achieving specified quality goals.
- consider specifying governance standards for entities contracting on a population basis which promote a strong primary care foundation and values the role of primary care in a multi-specialty, multi-stakeholder entity.

Include in this new standard the following modifications to the existing Standard Four requirement:

- Units of Service and Rates of Increase: Revise the current requirement to:
  - Add a cap on rate increases to hospital payments that includes the quality incentive.
  - Allow hospitals participating in population based contracts with downside risk to be exempt from the hospital rate cap.
- Quality Initiative: Retain the current requirement and add:
  - a requirement that the quality measures be based on nationally recognized measurement sets and target evidence-based activities that improve care and reduce costs, such as by 1) improving management of patients with chronic conditions and high risk patients, and 2) strengthening coordination among participating providers and across the continuum of care.
  - a prohibition against including quality incentive payments in the base rates to which rate increases apply.
  - a requirement that hospital-focused quality measures include measurement of the effectiveness of transitions of care processes.
  - a process, developed collaboratively with the insurers, to evaluate the effectiveness of their quality initiatives.
- Administrative Simplification: Eliminate this requirement.
- Care Coordination: Eliminate this requirement.
- Transparency: Retain this requirement. Consider requiring insurers to develop publicly available cost information for high volume episodes of care.
- **Cross Standard Recommendations**
  - To maximize the effectiveness of insurer incentives, explicitly allow insurers to make Primary Care Spend payments and the hospital quality incentive payments conditional upon meeting agreed upon performance requirements. Allow insurers to count allocated, but unearned Primary Care Spend and quality funds towards the insurer's Primary Care Spend target and hospital quality targets. Require insurers to distribute all unearned funds among providers that did meet the requirement(s).
  - As part of its rate review process, obtain information regarding whether the premiums paid by fully insured accounts accurately reflect the proportionate cost for programs from which these covered lives are benefiting. Factors that OHIC might use to evaluate whether fully insured accounts are paying their fair share are
    - whether the insurer has developed and implemented billing codes for functions as care management, and
    - whether insurers have amended self-insured account agreements to include funding the costs of those Affordability Standards from which they benefit.

Share the results of the data collection with insurers who are not spreading Affordability Standard costs to self-insured accounts.

- To enforce the Hospital Contracting and Payment Reform Standards efficiently and effectively, collect outcome measures that will indicate if the desired results are being realized. These measures would be reported annually by the insurers and could include:
  - Percentage of total payments paid under population-based payment methodologies
  - ROI analyses of at least two of the quality initiatives, in addition to an ROI analysis of the care coordination (transitions of care) initiative.
  - Weighted average annual increase in hospital payments.
  - Weighted average annual increase in population-based payments.

Based on the reported results, identify possible compliance issues and conduct in depth audits of those targeted areas.

## II. Introduction

In 2009 the Rhode Island Office of Health Insurance Commissioner (OHIC) established a set of standards designed to slow the growth of health insurance premium costs in Rhode Island by providing additional financial support for primary care providers and promoting health care payment reform. The standards were developed with the input and endorsement of the OHIC Health Insurance Advisory Council (AHIC), and collectively are referred to as the “Affordability Standards.”

The standards have evolved to some degree from creation to the current day. In their present form they are summarized as follows:

1. **Standard One:** Expand and improve primary care infrastructure (“Primary Care Spend Standard”). This standard requires insurers to improve the state’s primary care infrastructure by increasing the share of total medical payments made to primary care by one percent per year from 2010 to 2014 without raising premiums as a result of the increased primary care share. Periodically issued guidance from the OHIC Commissioner has detailed what type of spending would meet the requirements of this standard.
2. **Standard Two:** Spread the adoption of the patient-centered medical home (“Patient-Centered Medical Home Standard”). This standard requires insurers to provide financial support for the Rhode Island Chronic Care Sustainability Initiative (CSI).
3. **Standard Three:** Support *CurrentCare* (“*CurrentCare* Standard”) through financial support to *CurrentCare*, the Rhode Island health information exchange. This standard was originally structured to require insurers to support the adoption of electronic medical records within physician offices, but was changed in 2012 to the current requirement.
4. **Standard Four:** Reform hospital payment arrangements (“Hospital Contracting Standards”). While initially framed as a standard focused on comprehensive payment reform across the delivery system, the most recent guidance from the OHIC Commissioner at the time of the evaluation required insurers to meet the following six conditions when contracting with hospitals:

- a. **Units of Service:** Utilize unit of service payment methodologies for both inpatient and hospital outpatient services that realign payment to provide incentives for efficient use of health services, and are derived from nationally utilized payment practices other than fee-for-service, e.g., inpatient Diagnosis Related Groupings (DRGs) and outpatient Ambulatory Payment Classifications (APCs) in a form substantially derived from the Centers for Medicare and Medicaid Services (CMS).
- b. **Rate of Increase:** Limit average annual effective rates of price increase for both inpatient and outpatient services to a weighted amount equal to or less than the CMS National Prospective Payment System Hospital Input Price Index, for all contractual and optional years covered by the contract.
- c. **Quality Incentives:** Provide the opportunity for hospitals to increase their total annual revenue for commercially insured enrollment under the contract over the previous contract year by attaining mutually agreed-to performance levels for all or a subset of measures in the CMS Hospital Value-Based Purchasing Program for Medicare worth at least 2% of revenue. Subsequent guidance removed the 2% floor for all contracts signed after October 2012.<sup>2</sup>
- d. **Administrative Simplification:** Include terms that define the parties' mutual obligations for greater administrative efficiencies, such as improvements in claims and eligibility verification processes, and identify commitments on the part of each.
- e. **Care Coordination:** Include terms that require the hospital to measure and self-report to the designated Medicare Quality Improvement Organization (QIO), in a format and on a schedule determined by the Medicare QIO, its performance for nine specified best practices that have been documented to lead to improved quality of inpatient discharges and transitions of care.
- f. **Transparency:** Include terms that relinquish the right of either party to contest the public release of the any and all of these five specific terms by state officials or the participating parties to the agreement; provided that the issuer or other affected party may request the Commissioner to maintain specific contract terms or portions thereof as confidential, if properly supported with legal and factual analysis justifying confidentiality.

In November 2011, OHIC issued an assessment of the Affordability Standards and found that the three commercial insurers subject to the Standards<sup>3</sup>:

1. met the Standard One target of increasing primary care payments by one percentage point annually, and that each used a different strategy to do so;
2. continued their participation in and support of the Rhode Island CSI in compliance with Standard Two;
3. attested that they provided incentives to providers to adopt Electronic Health Records, and

---

<sup>2</sup> "The Affordability Standards: A Summary." Issued by the Rhode Island Office of the Health Insurance Commissioner on October 29, 2012.

<sup>3</sup> "Affordability Standards, Office of the Health Insurance Commissioner, November 2011." Available at: [www.ohic.ri.gov/documents/Insurers/Reports/Affordability%20Standards%20Assessment/3\\_2011%20Affordability%20Standards%20Assessment.pdf](http://www.ohic.ri.gov/documents/Insurers/Reports/Affordability%20Standards%20Assessment/3_2011%20Affordability%20Standards%20Assessment.pdf)

4. faced more challenges in meeting the payment reform goal and that compliance with the six payment reform conditions varied by insurer.

The assessment did not evaluate whether the Affordability Standards had made an impact on medical expense trends, noting that it was too early to do so.

A September 2012 report from OHIC assessed whether the three largest commercial insurers achieved their primary care spend targets specified in Standard One. The key findings of the report were<sup>4</sup>:

1. the insurers achieved their 2011 and 2012 spending targets;
2. primary care spending rose while total medical spending fell. Between 2007 and 2011, total primary care spending for commercial members increased by 23% while total medical spending fell by 18%. In 2012, insurers spent 8.0% of medical claims on primary care, up from 5.4% in 2007;
3. Patient-Centered Medical Home and other non-fee-for-service methods of payments drove the rise in primary care spending, and
4. primary care spending would continue to grow.

The goals of this new report are threefold. First, the report updates the earlier Affordability Standards assessments. Second, the evaluation considers the efficacy of each standard to achieve OHIC's desired aims. Third, the report provides recommended modifications to the Affordability Standards based on the evaluation.

The evaluation has drawn on both qualitative and quantitative data. Qualitative data have been obtained from interviews with physicians, hospital administrators, professional association representatives and insurer executives. One employer was also interviewed. A list of those interviewed is included in Appendix A of this report. In addition, an on-site review of each insurer's hospital contracts was conducted by a Bailit consultant.

Quantitative data, designed to determine whether the Affordability Standards have had desired impact on costs and utilization, were collected from the two largest insurers in Rhode Island. In addition, the three major Rhode Island insurers provided data to evaluate the spread of payment reform among the Rhode Island hospitals. The quantitative data request specifications are found in Appendix B of this report. Additional quantitative data were also obtained from annual insurer filings. To the extent possible, this analysis has used external benchmarks as a control to help isolate the impact of the Affordability Standards from general premium, utilization trends and federal payment reform activities.

### III. Discussion of Findings

Bailit collected both qualitative and quantitative data to assess both compliance with and the efficaciousness of the Affordability Standards. The qualitative data were collected through interviews with key stakeholders and chiefly reflect their personal opinions regarding the Standards. This first section discusses stakeholder understanding of the Standards, whether

---

<sup>4</sup> "Primary Care Spending in Rhode Island: Health Insurer Compliance & Initial Policy Effects." Office of the Health Insurance Commissioner, September 2012. See page 2. Available at [www.ohic.ri.gov/documents/Insurers/Reports/2012%20Primary%20Care%20Spend/Primary%20Care%20Report\\_FINAL.pdf](http://www.ohic.ri.gov/documents/Insurers/Reports/2012%20Primary%20Care%20Spend/Primary%20Care%20Report_FINAL.pdf)



they think the Standards have achieved their intended goals and whether they consider the Standards to be good public policy. Understanding the views of these stakeholders is important for two reasons. First, those interviewed are opinion leaders within their organizations and the Rhode Island health care sector. Whether they view the Standards as effective may have an impact on their long-term viability, since regulatory authority functions within a political environment. Second, understanding their perspective is also helpful in assessing whether the Standards have been understood and implemented as intended by OHIC. If it is found that industry leaders have a different understanding regarding the goals of the Standards compared to that envisioned by OHIC, structural and/or messaging adjustments may be needed in order to further the original goals. On the other hand, if the Standards are clearly understood as intended, future adjustments can focus on achieving expanded goals.

Following this section, each standard will be described and assessed separately. The recommendations to OHIC will be outlined in a separate section.

### **Stakeholders' Views of the Affordability Standards**

#### ***Awareness and Understanding of the Standards***

Generally, all the leaders interviewed had a solid understanding of the content and goals of the Standards. Not surprisingly, insurers' network contracting, medical management and legal office leaders had the most complete and thorough understanding of the Affordability Standards. The leaders of large hospital systems that also had physician practices participating in CSI felt they had a solid understanding of the Affordability Standards. The organizational leaders interviewed for this report consistently described their level of understanding as "moderate" to "detailed."

This awareness and understanding of the Standards appears to be generally limited to the top leaders of both physician and provider organizations. For example, the leader of a physician organization indicated that leaders of practices not participating in the CSI did not have an understanding of the Standards. A leader of a large hospital system indicated that at least several leaders of individual hospitals were not familiar with the Standards. Similarly, the employer interviewed acknowledged that he was an exception for knowing about the Standards and that few other employers were aware of them.

Through the interview process, it became clear that physician and practice leaders knew little about the hospital contracting requirements. Physician leaders consistently equated the Affordability Standards with CSI. That is, there was a widely held belief that the physician focus of the Standards was to support medical home transformation and that practices that did not participate in CSI received little to no benefit from the Affordability Standards. This perspective was based in reality. BCBSRI estimated that approximately 35% of the Rhode Island PCPs were the beneficiaries of the funds spent to meet Primary Care Spend Standard. United implemented a general fee schedule increase in 2010, but implemented a targeted approach in subsequent years. United estimates that approximately 500 out of Rhode Island's 850 PCPs have received Primary Care Spend funds from United. Because of its small market presence, Tufts Health Plan ("Tufts") was not required to meet the Primary Care Spend Standard.

#### ***Identification and Achievement of the Goals of the Affordability Standards***

The interviewees identified a wide range of specific goals for the Affordability Standards that relate to the broad goal of lowering health care costs, including: promoting medical homes, supporting PCP infrastructure development, increasing PCP payments, and promoting payment reform.

Everyone interviewed believed that the Affordability Standards have been successful in promoting medical homes and have been instrumental in moving primary care practices in that direction.<sup>56</sup> BCBSRI stated that OHIC's support of medical homes was consistent with activities the insurer had been promoting and that requiring all other insurers to pursue similar policies has had a significant impact in creating momentum for real change. Several interviewees stated that having the State of Rhode Island as a partner in promoting primary care practice reform was essential in making it happen.

Both insurers and hospitals acknowledged that the Hospital Contracting Standard has had a profound impact on reducing the rate of payment increases and in that regard has been very successful in meeting the goal of reducing costs. Not surprisingly, the insurers reported that the changed dynamic is positive, while the hospitals did not. A more detailed discussion of the impact of the Affordability Standards on insurer-hospital relationships is presented below.

All applauded OHIC's support of *CurrentCare* and believed that OHIC support would make a difference in the initiative's success. The interviewees believed that the development of this health information infrastructure would ultimately improve cross-provider and provider-to-patient communications.

Those interviewed did not believe that the ultimate goal of reducing health care costs had been achieved because the changes envisioned by the Affordability Standards with regard to changing how primary care is delivered would take years to complete. As a result, the interviewees believed that the Standards had only partially met their goals. One insurer explained that the Affordability Standards as currently constructed are paving the way for the next milestone, which is the systemic shift away from fee-for-service payments to more profound payment reform. Several did not think that OHIC had the regulatory power or breadth of authority to ever effectively impact costs in a sustainable way, noting the role of government payers and public health variables as cost drivers out of the control of OHIC. One noted that the Hospital Contract Standards might have the most impact, but that it was too early to make that assessment.

Both providers and employers thought that the increased primary care payment requirement would not reduce costs because 1% a year is not sufficiently large to close the PCP – specialist gap, and primary care spend remains such a small percentage of total spend.

### ***Affordability Standards as Good Public Policy***

---

<sup>5</sup> One hospital system administrator noted that his hospitals actively support CSI by providing additional nurse care manager time to affiliated practices over and above the CSI support. He saw this level of support as an important reflection of the mission of his hospitals.

<sup>6</sup> One physician leader attributed his organization's ability to obtain a contract with UnitedHealthcare to the requirement to increase PCP payments. He shared that he had tried to obtain a contract with United for 10 years, and shortly after the Affordability Standards came out, he reported that United came to him with a contract offer. United confirmed that the Affordability Standards had provided United with a "new opportunity" to work with this primary care organization.

The insurer leaders who were interviewed were asked if they thought the Affordability Standards were good public policy. In one way or another, they all said that public policy that incentivizes affordability and improves quality of care is good public policy. One insurer singled out supporting PCP infrastructure development as a particularly important public policy goal. All leaders interviewed cautioned against Affordability Standards that were too prescriptive, limiting insurer flexibility and creativity. Examples of initiatives they want to pursue if the related costs are recognized in the future as Primary Care Spend include sharing specialty performance data with primary care practices to support building a medical neighborhood and moving from the current CSI model of advanced PMPM payments to practices to paying practices based on outcomes.

While not specifically asked if the Affordability Standards were good public policy, several physician interviewees independently described the Affordability Standards as being visionary, one describing the Standards as providing a “North Star” for the future of health care in Rhode Island.

### **Standard One: Expand and Improve Primary Care Infrastructure**

Standard One requires insurers to expand and improve the state’s primary care infrastructure by increasing the share of total medical payments made to primary care by one percent per year from 2010 to 2014 without raising premiums. Guidance memos from OHIC, which were issued in March 2011 and May 2011, outlined areas of investments by health insurers that would meet the requirements of the Affordability Standards. Those areas include money spent by insurers:

1. in payments to primary care physicians and primary care practices, including direct payments for health care services, quality incentive payments, payments for structural changes to practices (e.g., EHRs) and payments for supplemental staff or activities (e.g., patient educators, patient navigators);
2. for services provided by a third party integrated into the primary care setting - to either support patients or the practice itself (e.g., in kind support by insurers, such as nurse care managers who are employees of the insurer, but embedded in the primary care practice);
3. in support of CSI;
4. to promote early and comprehensive access to high quality primary care for children, consistent with CPT coding and newly developed children’s preventive screening schedules (e.g., after hours telephone calls, email communications), and
5. to build primary care workforce capacity (e.g., loan forgiveness programs for clinicians.)

To further drive primary care infrastructure development, the OHIC guidance required insurers in 2012 to direct 30% of its primary care spend funds to activities other than to fee-for-service payments. OHIC waived the requirement that 25% of its primary care funds go towards other than fee-for-service payments in 2011 because of the lack of timely notice to the insurers of the requirement. A January 11, 2013 guidance memo has increased the percentages of non-fee-for-service payments for 2013 and 2014 to 40% and 45%, respectively, and restructured the type of spending that meets the requirements of the Affordability Standards. In light of the timing of this report, this analysis will focus on assessing the requirements included in the March 2011 and May 2011 guidance memos.

The focus of this section of the report is to understand both qualitatively and quantitatively what impact these payments have had. In considering how to assess impact, Bailit evaluated potential impact from several different perspectives, including:

1. whether the requirement to increase primary care spending by 1% annually has been met by the insurers;
2. interviewee perceptions whether the increased payments have directly resulted in changes in practice dynamics, such as improved organizational stability, staff and provider retention, etc.;
3. how the funds were used by the practices, and
4. whether there has been any measurable impact on utilization and costs resulting from a larger investment in primary care.

This report section also includes a discussion of barriers and challenges identified during the evaluation process.

### *1. Achievement of 1% Primary Care Spend Requirement*

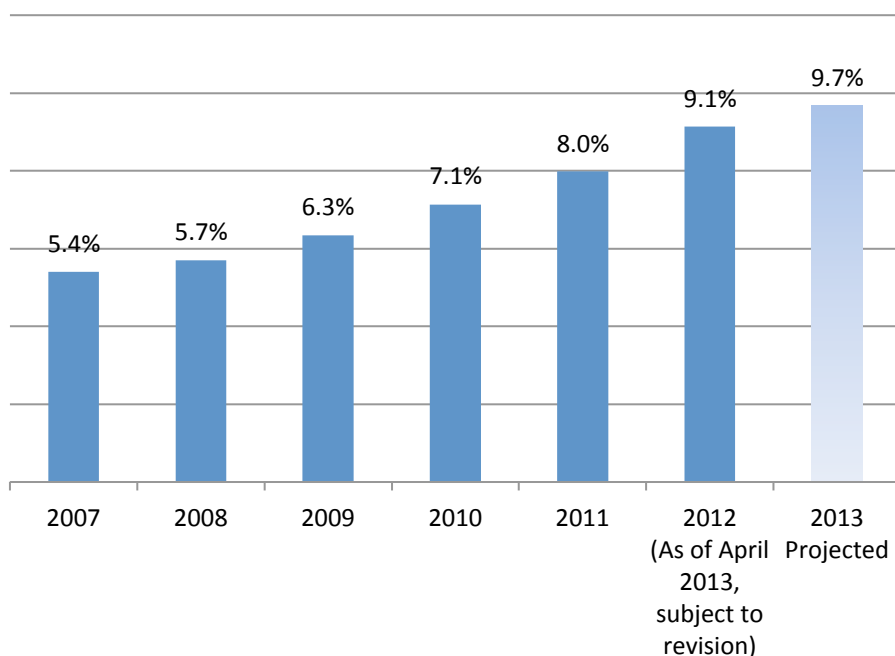
In a summary of the Standards, dated October 2012, OHIC defined the 1% Primary Care Spend requirements as stipulating that issuers improve the state's primary care infrastructure by increasing the share of total medical payments made to primary care by one percentage point per year from 2010 to 2014.<sup>7</sup> To assess compliance with this standard, Bailit looked at the change in the percent of total health care payments that were designed for primary care both in aggregate and for each insurer. Because total health care expenditures dropped between 2008 and 2012, which would result in an increase in the percentage of payments to PCPs even if the PCP payments stayed the same in absolute dollar amounts during that period, Bailit also looked at the percentage increase in absolute dollars paid to primary care practices during the measurement periods.

In aggregate, primary care spending is increasing as a percent of total medical spending for the three largest insurers. This trend began before the implementation of the affordability standards in 2010, but has accelerated since 2010 as shown in the figure below. This accelerated trend documents the impact of the Primary Care Spend Standard to increase PCP funding.

---

<sup>7</sup> "The Affordability Standards: A Summary." Issued by the Rhode Island Office of the Health Insurance Commissioner on October 29, 2012.

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



The data displayed in the graph above represent data from BCBSRI and United from 2007 to 2012 and data from Tufts from 2009 to 2012; insurers made projections for 2013. Overall, this aggregate trend shows an increase in overall insurer investment in primary care of 0.9 percentage points between both 2009 and 2010 and between 2010 and 2011, 1.1 percentage points between 2011 and 2012 and a projected increase of 0.6% between 2012 and 2013. These rates are significantly greater than the increase between 2007 and 2008 (0.3 percentage points) and between 2008 and 2009 (0.6 percentage points), both time periods before the Standards went into effect. In aggregate, the share of spending on primary care increased from 5.4% in 2007 to 9.1% in 2012, an increase of 69%. However, in 2013 it does not appear that the insurers will be in compliance with the requirement, which should be investigated by OHIC.

In examining individual insurer performance, the data indicate that BCBSRI increased its share of primary care spending by one percentage point (from 7.2% in 2010 to 8.2%) in 2011 and based on unadjusted data appears to have increased it 1.2 percentage points (projecting 9.4%) in 2012<sup>8</sup>. Looking forward, BCBSRI's goal for 2013 is 9.8%, representing a 0.4 percentage point increase, which is below the requirement of 1%. This should be pursued by OHIC.

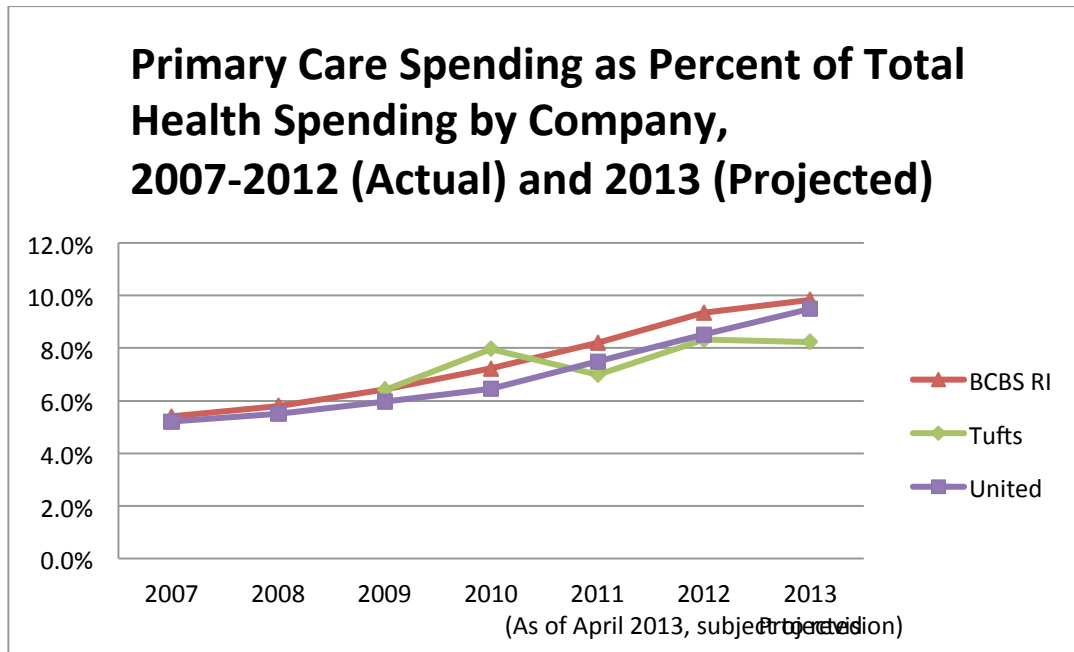
United increased its share of primary care spending by one percentage point each year from 6.5% in 2010 to 7.5% in 2011 and based on unadjusted data appears to have reached 8.5% in 2012<sup>9</sup>. United's goal for 2013 is 9.5%.

<sup>8</sup> Based on the April 15, 2013 Primary Care Spend Standard Submission filings to OHIC.

<sup>9</sup> Based on the April 15, 2013 Primary Care Spend Standard Submission filings to OHIC.

Because of its small market share, Tufts has not had specific spending goals set by OHIC. The data indicate that its percentage of primary care spending decrease from 8.0% in 2010 to 7.0% in 2011 and then, based on unadjusted data, increase to approximately 8.3%<sup>10</sup> in 2012. Looking forward Tufts is showing a forecast of 8.2%.<sup>11</sup>

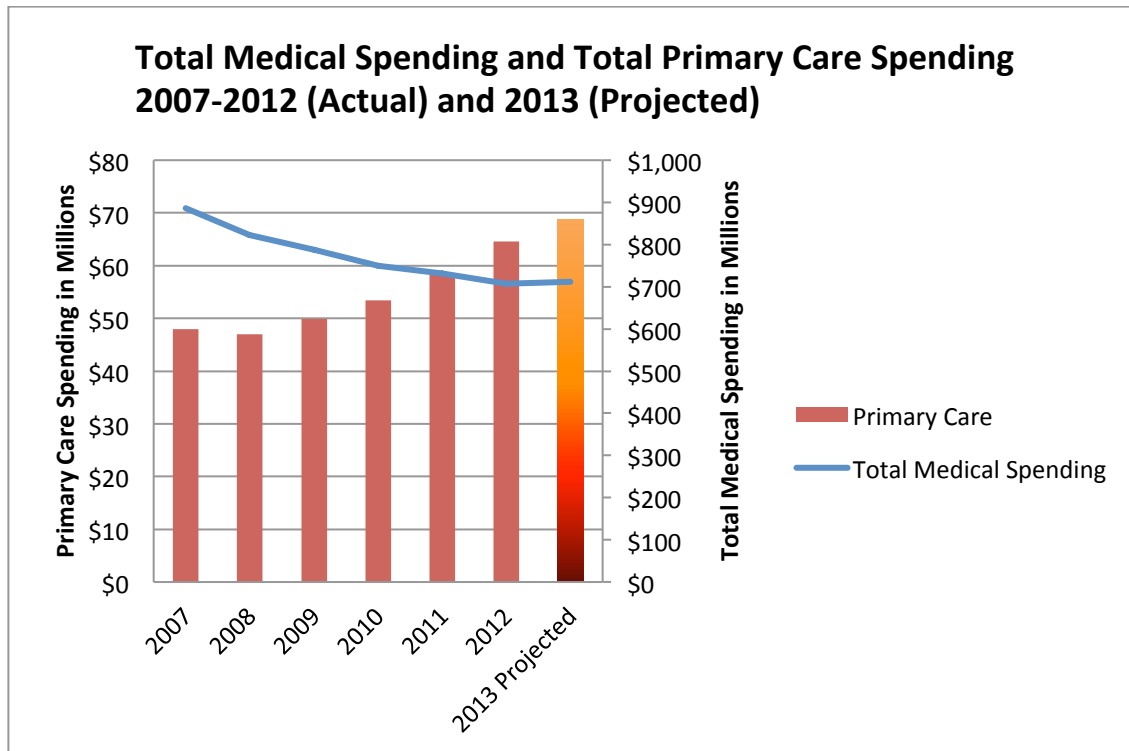
The following graph depicts primary care spending as a percentage of total spending by insurer.



Concerned that a decrease in overall medical spending might mask the true level of increase in primary care spending, Bailit looked at the percentage of increase in actual and projected dollars for primary care. In looking at dollars spent, the data indicate a decline in total medical spending while there has been an increase in dollars directed towards PCPs, as indicated in the following chart.

<sup>10</sup> Based on the April 15, 2013 Primary Care Spend Standard Submission filings to OHIC.

<sup>11</sup> These percentages are based on the April 15 2013 Primary Care Spend Standard Submission filing and may be different from previously published reports due to changes in how specific provider types are categorized.



The following chart indicates the percent change in total dollar spending for primary care year-over-year for each insurer. With the exception of 2007/2008, both BCBSRI and Tufts are increasing the absolute dollars in primary care spending at rates that exceed one percent annually.

United’s level of primary care spending decreased in the years prior to the implementation of the Affordability Standards, and then significantly increased its spending in 2010/2011. Spending in 2011/2012 was increased by one percent, but is expected to be flat in 2013. At the same time, United is projecting a 1 percentage point increase in spending for primary care between 2012 and 2013. In order to achieve the increase in primary care spending to meet the Primary Care Spend Standard, they are forecasting a 10% reduction in total medical spending. This forecast of reduced overall medical spending is concerning because it is inconsistent with a Price Waterhouse Cooper Health Research Institute projection that medical costs will increase 7.5% for 2013 and is inconsistent with national trends.<sup>12</sup> This issue warrants OHIC attention.

<sup>12</sup> See [www.pwc.com/us/en/health-industries/behind-the-numbers/key-findings.jhtml](http://www.pwc.com/us/en/health-industries/behind-the-numbers/key-findings.jhtml). Accessed on May 6, 2013.

Percent Change in Total Dollar Spending of Primary Care Payments, 2007 - 2012 (Actual) and 2013 (Projected)							
	2007/ 2008	2008/ 2009	2009/ 2010	2010/ 2011	2011/2012 (As of April 2013, subject to revision)	2012/ 2013 Projected	Compound Annual Growth Rate 2007- 2013 (2009-2013 for Tufts)
BCBSRI	-1%	2%	7%	5%	13%	8%	5.7%
Tufts			37%	-1%	19%	4%	14.0%
United	-3%	-3%	-2%	32%	1%	0%	3.4%

### *Bailit's Assessment*

When evaluating insurer primary care spending as a percentage of total medical spending, both BCBSRI and United met the Standard between 2010 and 2012. Tufts did not have a spending goal. In 2013 BCBSRI is projected to increase its primary care spending by 0.4%, not by 1%. While, BCBSRI's total projected primary care spending in 2013 will exceed the spending projections of both United and Tufts Health Plan and BCBSRI's level of spending in 2010 was higher than the other insurers, its own projections indicate it will not meet the Standard.

Although United is projecting a 1% increase in 2013, it appears to do so by projecting a 10% drop in total spending in 2013. This is concerning for two reasons. The projection is not supported by national projections or recent experience and it is not consistent with the spirit of the Primary Care Spend Requirement.

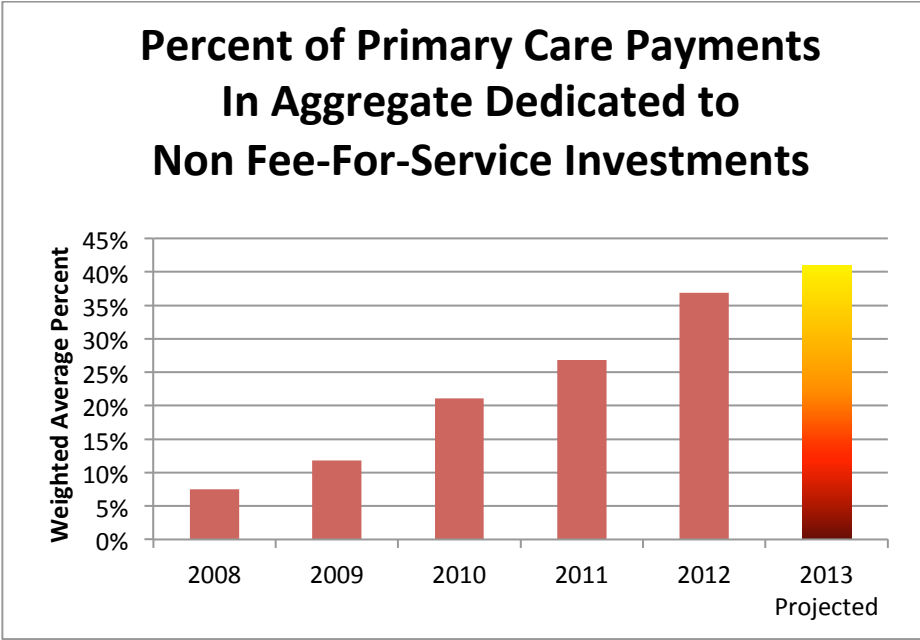
When examining the percentage increase in actual dollars spent on primary care, the data indicate that the rate of increased funding for BCBSRI and Tufts has exceeded one percentage point a year, after 2007. United's rate of increase in actual dollars spent on primary care varies widely from year to year and may warrant further investigation.

### *Achieving the 30% Spending-on-other-than-Fee-for-Service Requirement*

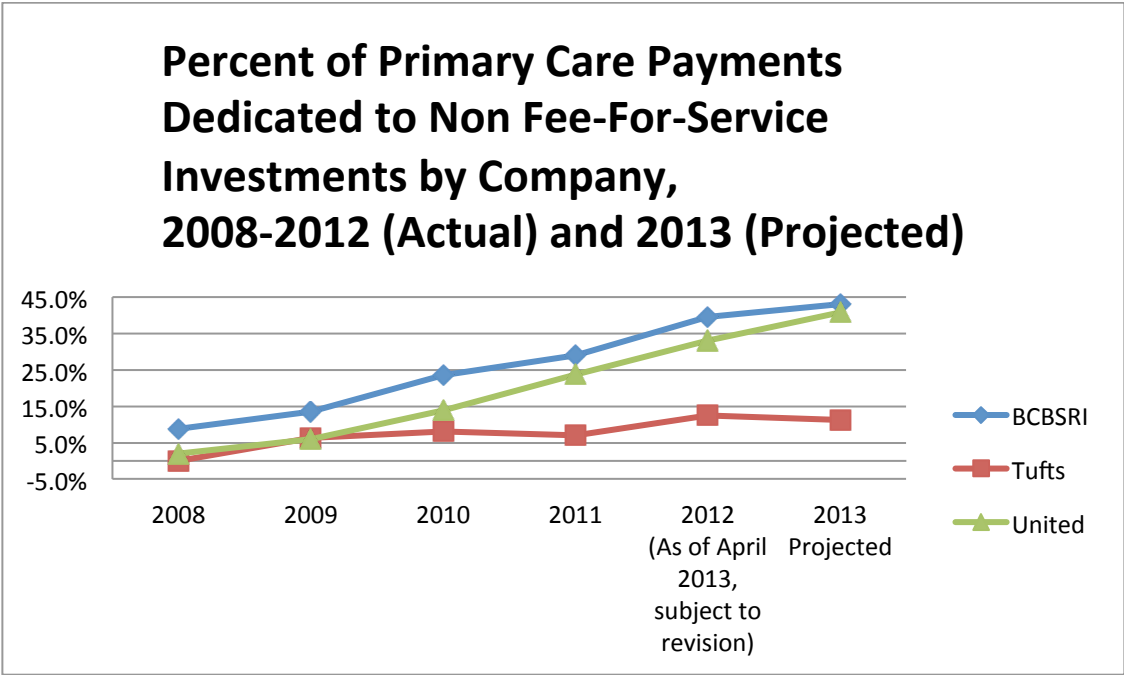
In addition to increasing the percentage of primary care spending annually, the insurers are required to direct at least 30% in 2012 to areas other than fee-for-service payments.

Based on a review of the available data, the insurers in aggregate have met this goal. The table below reports the percentage of aggregated primary payments that were directed to areas other than fee-for-service payments. The level of non-fee-for-service payments appears to have increased significantly in 2012, as the OHIC requirement became effective.

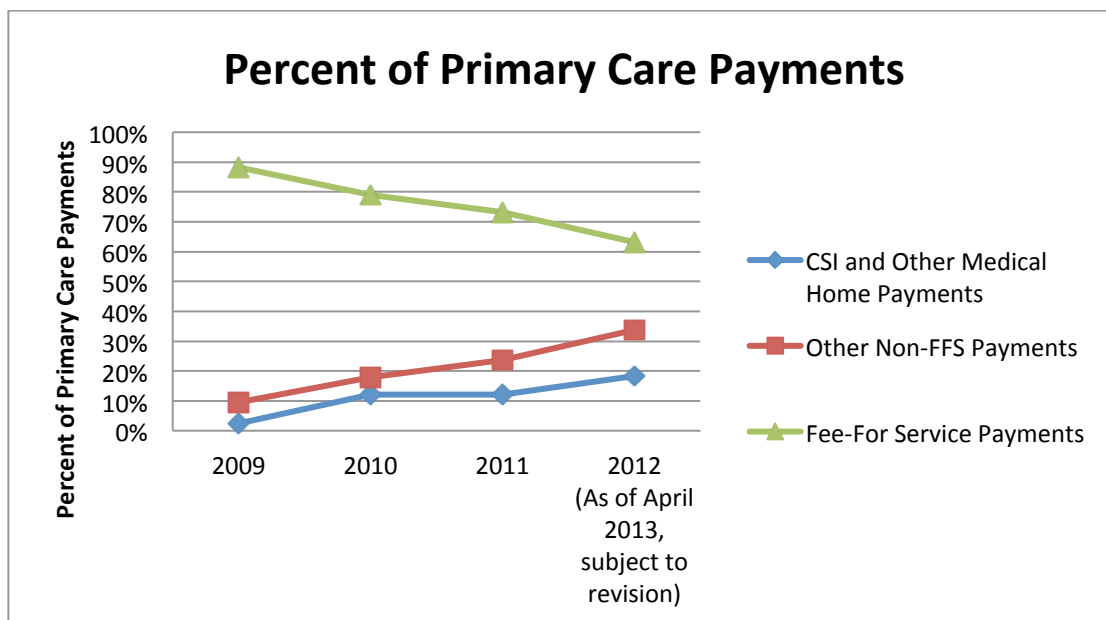




When examining individual insurer performance, both BCBSRI and United exceeded the 30% goal in 2012. Tufts Health Plan, although not subject to the Standard, is significantly below the target. The following chart depicts the percentage of primary care spending dedicated to payment other than fee-for-service reimbursement for each insurer.



When looking at data that aggregates the Primary Care Spend into three broad groupings – medical home payments, other non-fee-for-service payments and fee-for-service payments – the impact of Standards One and Two on payment patterns is very clear. The graph below clearly documents the growth in allocation of funds to medical home and non-fee-for-service spending with the related decline in fee-for-service payments.



An examination of the insurer filings regarding the categories of non-fee-for-service spending indicates in the charts below that non-FFS spending approximately doubled between 2009 and 2010 and has continued to increase consistently through 2012. In 2010 and 2011, the two major categories of spending were medical home payments and non-FFS incentive payments, accounting for approximately 77% of all non-FFS spending in 2010 and 88% in 2011. The allocation in 2012 indicates a shift. First, the funding of HIT increases significantly as insurers, primarily BCBSRI, direct funding to CurrentCare. Second, the funding for non-FFS incentive payments decreased as BCBSRI shifted funding from that category to medical home support. In 2012, approximately 48% of funding is directed towards medical home payments and non-FFS incentive payments.

Primary Care Spending on Non-FFS Spending				
	2009	2010	2011	2012
Medical Home Payments	\$1,005,972	\$6,491,114	\$7,081,160	\$11,805,367
HIT	\$264,000	\$622,136	\$548,539	\$4,239,319
Loan Forgiveness	\$500,000	\$250,000	\$0	\$350,000
Non-FFS Incentive Payments	\$450,000	\$2,276,961	\$ 5,822,110	\$3,075,384
Other <sup>13</sup>	\$3,697,266	\$1,769,703	\$2,331,590	\$4,310,255
Total	\$5,917,238	\$11,409,914	\$15,783,399	\$23,780,325

### Bailit's Assessment

Both BCBSRI and United have achieved the requirement that at least 30% of primary care spending be directed to non-fee-for-service investments.

<sup>13</sup> "Other" non-FFS expenses include behavioral health investments, provider reporting, and other approved expenses.

Based on the data that indicate an acceleration in primary care spending that coincides with the implementation of the Affordability Standards and based on the interview findings, the Primary Care Standard appears to have had a profound impact on primary care practices ability to transform according to insurer and practice representatives. United's method of meeting the Primary Care Spend requirement in 2013 should be directly addressed by OHIC.

OHIC has begun to more proactively shape how the non-FFS spending should be directed. The January 11, 2013 guidance memorandum from Commissioner Koller to the insurers increases the percentage of non-FFS funding to 40% in 2013 and 45% in 2014 and specifies support for CSI expansion and CurrentCare as required areas of funding. Insurers are also given a short list of options for allocating other non-FFS funds, two of which support capacity development for primary care practices to accept financial responsibility for population health management. This approach warrants careful monitoring to determine if the funding patterns achieve program aims and allow sufficient flexibility to be responsive to developments on the ground.

Bailit raises the question as whether support of CurrentCare should count towards the primary care spend requirement, since the intent of Standard One was to direct funds to primary care practices. While CurrentCare supports the delivery of care across the continuum, insurer payment for CurrentCare does not, in fact, constitute payment to primary care providers. Arguably, the increase in HIE funding in 2012 resulted in a reduced level of funding of other initiatives, such as medical home programs and non-FFS incentive programs, that represent more direct payments to primary care practices.

### *Qualitative Evaluation of Primary Care Spend Standard*

Bailit interviewed several practice leaders to gain an understanding of what the Primary Care Spend Standard has meant for practices. Bailit asked the interviewees about indicators of improvement of conditions of practice, such as improved PCP reimbursement and reduced staff turnover. The intent was to determine if the increased funding of primary care practices has resulted in better conditions and, thereby, will ultimately improve primary care access and primary care practice performance, all to improve affordability of health insurance. We also wanted to know if the practices were spending the funds received in a manner that was consistent with the OHIC guidance. The following is a discussion of the findings from those interviews.

### *Changes in Practice Dynamics*

- ***Improve PCP reimbursement:*** The two major insurers in Rhode Island report implementing a targeted approach to distributing their 1% increase in PCP spending. Each explained that it wanted the funds to result in changes in delivery design and believed that targeting the funds would be more successful in promoting change than a general fee schedule increase. In explaining its strategy, one insurer stated that if the 1% payments were viewed by providers as an entitlement, rather than something that needed to be earned, no change in care delivery would result.

The practices generally used additional funding to build practice infrastructure, rather than increase physician salary and rates. One physician leader explained that he saw the Affordability Standards not as a vehicle to improve PCP reimbursement, but as a way to build quality improvement infrastructure through CSI. One practice included within the definition of infrastructure development the payment to physicians for "meaningful,

important and patient-related” activities not eligible for compensation under the fee-for-service system to offset for time that would otherwise have been spent in revenue-generating activities.

- ***Improve organizational and financial stability.*** The more farsighted leaders who were interviewed saw the process of reorienting a primary care practice into a medical home as increasing organizational stability because the practice of the future must be able to survive in an environment focused on quality and cost effectiveness. Others reported receiving comfort knowing that Affordability Standard funding would cover infrastructure costs that the practice had initially self-funded in order to move the practice transformation forward. The level of Affordability Standard funding was not considered sufficient to fund all necessary changes, but was viewed as an important “piece of the funding puzzle” that supports change.
- ***Improve access to primary care:*** The physicians interviewed generally did not think the Affordability Standards improved access; rather they saw the funding as improving the quality of care provided.
- ***Retain physicians.*** None of the physicians interviewed believed that the Affordability Standard payments had impacted physician retention. However, one practice reported that one local, established physician changed practices to join their CSI practice because of the innovative changes being made in the CSI practice. Practices are finding it increasingly hard to compete with hospitalist salaries being offered by hospitals to general internists. Moreover, compensation for recently minted residents reportedly requires a three-year commitment to a salary that exceeds that of experienced Rhode Island primary care physicians. Another physician leader indicated that Rhode Island salaries are competitive with surrounding states, but that total compensation is higher in Massachusetts, making attracting physicians difficult. Although they did not think that the payments directly helped with retention, several interviewees believed that the payments helped to create an organization that is able to broaden support for clinicians through the medical home infrastructure changes and thus create a more desirable setting in which to practice.
- ***Retain staff.*** Physician leaders saw the benefit to practice staff as being indirect through the practice’s ability to run an organization that is current on technology, has adequate staffing and creates a positive work environment.
- ***Impact on residency programs:*** Leaders of the Rhode Island residency programs either did not know what the Affordability Standards were or said that they were not a factor. The biggest barrier to filling primary care residency programs is the income gap between primary care and specialists.

### ***How supplemental funding is spent by PCP practices***

Within practices interviewed, the funding was used to fund infrastructure development. Practices used the supplemental funding to build medical home infrastructure, including in the following areas:

- **Hiring new staff:** At a minimum, practices hired nurse care managers. Other new staff added by practices included non-clinical assistants to run population metrics, medical assistants, and a health IT trainer.
- **Office renovations:** One practice modified its office space so that it could co-locate a psychiatrist, dietician and podiatrist.
- **Equipment:** One practice added a machine to perform HbA1c tests in the office in order to obtain results more quickly and respond to identified problems during the office visit.
- **IT services:** One practice reported building a web-based system to enhance primary care – behavioral health provider communications. The system identifies available behavioral health providers who meet the patient’s needs and sends an electronic message to set up the appointment. It also enables the behavioral health specialist and the PCP to communicate clinical information to one another. A second practice added a patient portal, software to run quality reports and patient registries for diabetes, asthma and immunizations. The software also interfaces with commercial and hospital-based labs.
- **Staff bonuses:** One practice indicated that it had implemented a bonus for staff members to achieve medical home quality targets.

### **Bailit’s Assessment**

The areas of spending by both the insurers and the practices are consistent with insurer reports to OHIC detailing where their funding has been directed and with the guidance provided in the March 2011 and May 12, 2011 guidance memos from OHIC to the insurers. As stated by Commissioner Koller in his March 2011 guidance, “This money should be an investment in improved capacity and care coordination, rather than a simple shift in fee schedules.”

The funding of CSI practices has reportedly improved the practice environment by building infrastructure to enable practices to be better positioned for the future. Those interviewed report that transformation activities are time consuming and require a long-term commitment. Concern was expressed as to whether the level of funding is adequate to complete the transformation process. This is a concern in light of the apparent level funding by United going into 2013 and the decrease in the rate of increased funding by BCBSRI.

While the dollars are helping build primary care infrastructure, they are not helping to raise primary care compensation and make it easier to attract primary care physicians to the state. Increasing primary care supply was one of the rationales for the primary care spend goal.<sup>14</sup>

### **Impact on Utilization**

As part of evaluating the impact of the Primary Care Spend, BCBSRI and United submitted data on measures that may be impacted by increases in primary care investment. Tufts was exempt from this requirement because of its relatively small membership in Rhode Island.

---

<sup>14</sup> See January 11, 2013, memo from Christopher F. Koller, Health Insurance Commissioner, entitled “Affordability Standard One (Primary Care Spend Standard) 2013 and 2014 Guidance”

The purpose of this aspect of the assessment is twofold: to determine if the investment in primary care infrastructure resulted in changes in a) utilization patterns, and b) the level of access experienced by Rhode Islanders. Wherever possible, regional or national benchmarks were employed as a comparison in order to isolate the impact of the Primary Care Spend Standard from general marketplace changes.

For this aspect of the assessment, Bailit collected insurer data to assess the following evaluation metrics:

- incidence of inpatient hospitalization for ambulatory care-sensitive conditions
- incidence of emergence room visits for ambulatory care-sensitive conditions
- HEDIS<sup>15</sup> measure: adults' access to preventive/ambulatory health services
- HEDIS measure: children and adolescents' access to PCPs
- HEDIS measure: well-child visits in the first 15 months of life (6 or more visits)
- HEDIS measure: well-child visits in the 3<sup>rd</sup>, 4<sup>th</sup>, 5<sup>th</sup> and 6<sup>th</sup> years of life
- HEDIS measure: adolescent well-care visits
- HEDIS measure: ED visits/1000 member months
- HEDIS measure: inpatient discharges/1000 member months
- PCP visits per 1000 member months
- specialists visits per 1000 member months

All measures are reported as weighted averages for all insurers submitting data. The weighted average was calculated by summing across the submitted insurer numerators and denominators and calculating the resulting rate.

A number of challenges arose in the collection of the aforementioned measures:

- ***Defining the population that was to be measured.*** Rhode Island is a small state which borders the larger states of Connecticut and Massachusetts. This fact results in two related problems: a) a large proportion of the people insured in Rhode Island live in and may seek care in bordering states and b) Rhode Island residents seek care from out-of-state providers. In order to focus on the population of insured members seeking primary care in Rhode Island, insurers submitted data using the following population definition: commercial, fully insured and self-insured HMO and PPO members who live in RI and bordering counties in MA and CT and have been attributed to PCPs in Rhode Island. For most of the measures, BCBSRI was able to provide data using this definition. For the HEDIS measures, United provided the HEDIS results for insurers offered to Rhode Island residents, some of which had significant membership in other states. United did use the requested definition for the ambulatory care-sensitive condition measures.
- ***Obtaining complete, comparable data over multiple years.*** The insurers were asked to provide data from the years 2008 through 2012. The health insurers were able to provide data for the first three quarters of 2012, with three months of claims run out. Data from the last quarter of 2012 were not available. For the HEDIS measures, insurers

---

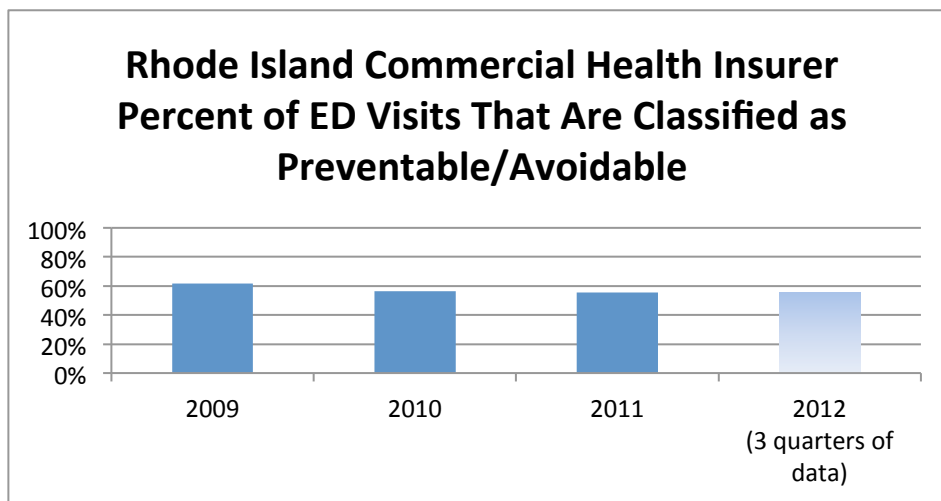
<sup>15</sup> The Healthcare Effectiveness Data and Information Set (HEDIS) is a widely used set of performance measures developed and maintained by the National Committee for Quality Assurance to measure insurer performance against other insurers, as well as against national and regional benchmarks.

were not able to provide data for 2012 as they had not completed the data collection process for the year. Finally, United was unable to provide 2008 data for most of the measures because it had moved the data to an archive and was not able to run queries in a timely manner.

### *Ambulatory Care-Sensitive Conditions*

The data for the measure of ‘reduced incidence of inpatient hospitalization for ambulatory care-sensitive conditions’ showed only minimal change annually between 2009 and 2012. As a result, the Affordability Standards appear to have no impact on this measure to date.

The data for the ‘reduced incidence of emergence room visits for ambulatory care-sensitive conditions’ shows a slight, but noticeable decline in 2010 that appears to be maintained through three quarters of 2012 as indicated in the following graph.



No known national benchmarks tracked this measure over time; therefore, it is not possible to determine if this decline is a national trend or whether it is due to the recession and/or improved primary care services in Rhode Island. Several reports indicated that the level of preventable ED visits in Rhode Island is in line with findings in other states. With approximately half of all ED visits preventable, there appears to be a significant opportunity to reduce costs through more appropriate use of ED services.<sup>16</sup>

### *HEDIS Access to Care Measures*

None of the HEDIS access measures was illuminating. Rhode Island providers performed above the regional average for all measures and performance, in general, was very high. The

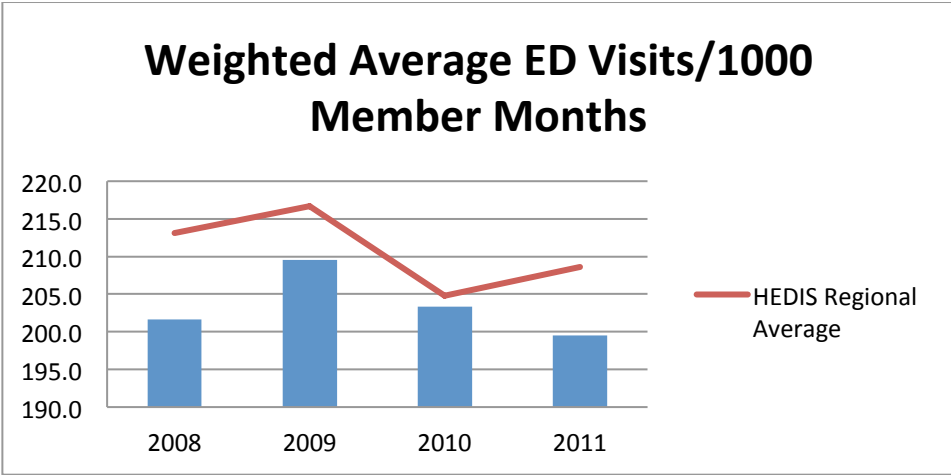
<sup>16</sup> See “BCBS Michigan Physician Group Incentive Program 2012 Program Year Emergency Department Utilization Initiative.” Available at: [www.npoinc.org/local/upload/fckjail/generalcontent/54/file/Emergency\\_Department\\_Utilization\\_External\\_Initiative\\_Plan.pdf](http://www.npoinc.org/local/upload/fckjail/generalcontent/54/file/Emergency_Department_Utilization_External_Initiative_Plan.pdf) and Chang C., et al. “Non-urgent ED use in Tennessee, 2008.” University of Memphis Methodist Le Bonheur Center for Healthcare Economics. August 2011.

Affordability Standards do not appear to have impacted these measures. Charts for the following non-impacted measures are included in Appendix C:

- Percent of Preventable Discharges for Ambulatory Care-Sensitive Conditions
- Adult Access to Preventive/ Ambulatory Health Services
- Children and Adolescents’ Access to PCPs
- Well-Child Visits in the First 15 Months of Life (6 or more visits)
- Well-Child Visits in the 3<sup>rd</sup>, 4<sup>th</sup>, 5<sup>th</sup> and 6<sup>th</sup> Years of Life
- Adolescent Well-Care Visits
- Inpatient Discharges/1000 Member Months

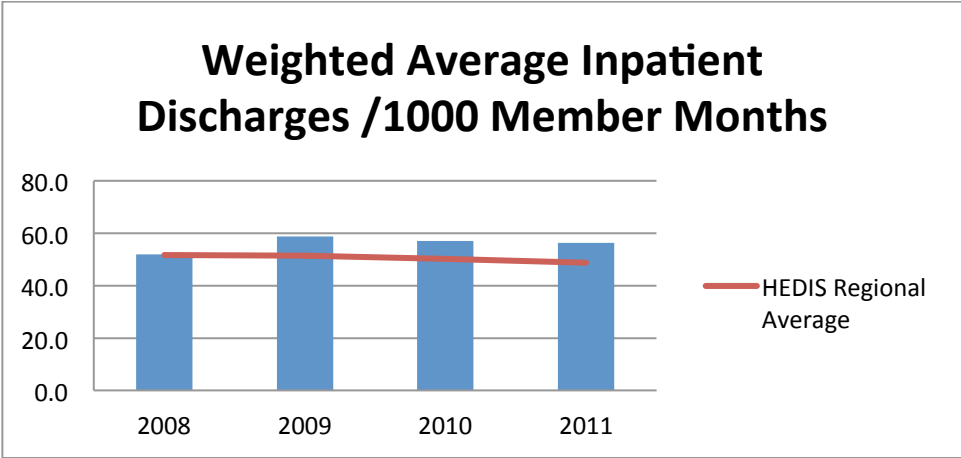
**Utilization per 1000 Member Month**

Bailit looked at three utilization measures that may be impacted by improved primary care services. The most interesting measure is ‘weighted average ED visits/1000 member months’ which shows a drop in ED visits/1000 member months in 2011 at a time when the HEDIS regional average is increasing. In other years the Rhode Island trend mirrored the regional trend. While one cannot assume a causal connection between the Affordability Standards and a reduction in use of ED visits, there may be a correlation which could become clearer over time. The impact of the recent recession, which impacted Rhode Island more severely than other Northeastern states, may have also been a major contributing factor in reduced ED utilization. The data are presented in the following graph.

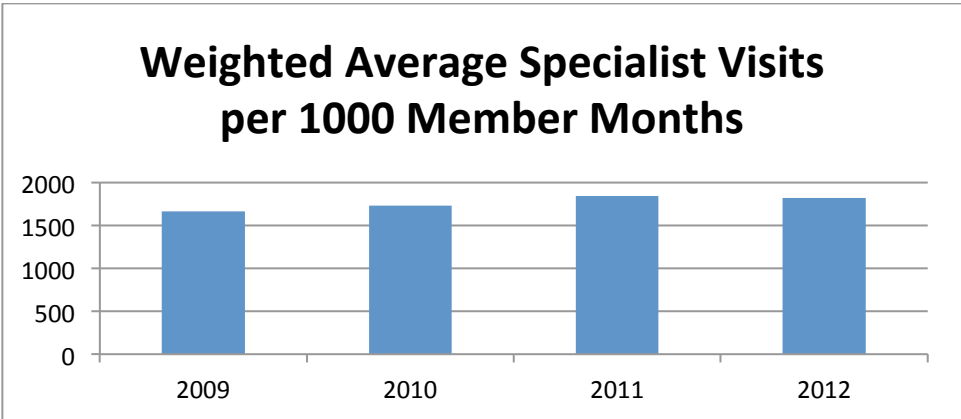
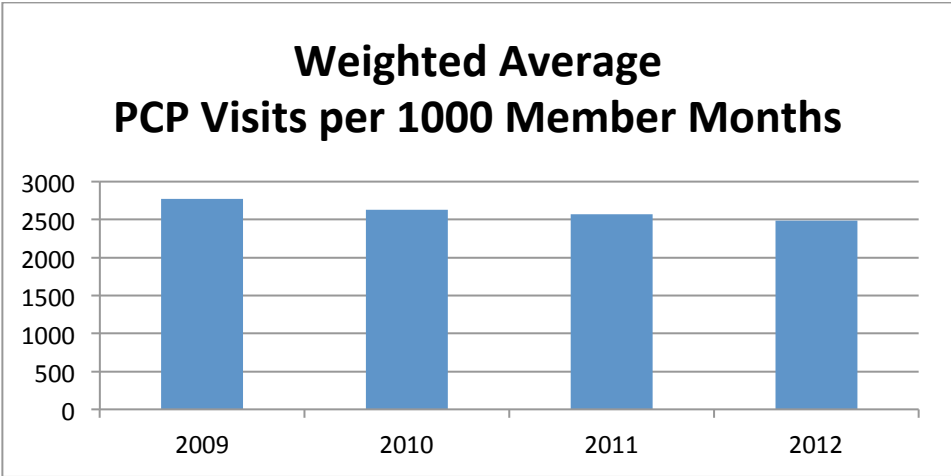


The weighted average inpatient discharges/1000 member months remains consistently above the HEDIS Regional average from 2009 through 2011 with a slight decline starting in 2010 and holding in 2011. The decline appears to be consistent with the movement of the HEDIS regional average, suggesting that there is no impact from the Affordability Standards on this measure. This is consistent with no change with regard to ‘ambulatory care-sensitive inpatient admissions’ measure discussed above.





The last two utilization measures examined are PCP visits per 1000 member months and specialist visits per 1000 member months. These data show PCP visits slightly declining and specialist visits slightly increasing. Since there are no national benchmarks for these measures, it is not possible to know if these trends were seen regionally or nationally. It is worth noting that the null hypothesis is that opposite trend would have occurred, with PCP visits increasing and specialty visits decreasing as primary care services were enhanced.



## Bailit's Assessment

**Utilization Measures:** Utilizing statewide utilization metrics to assess the impact of Standard One is challenging since it is estimated that fewer than half of all Rhode Island primary care physicians have been directly impacted by the standard.

That being said, the Affordability Standards may possibly be positively impacting ED utilization, since both ED utilization per 1000 member months and the number of ambulatory-sensitive care ED visits appear to have declined in recent years. The sustained recession in the state may be the primary contributor, however. It will be important to continue to track these measures as the number of participating CSI practices expands and insurers continue to support primary care transition. The other measures for which data were collected did not reveal patterns suggesting an impact from the Affordability Standards

**Standard One Overall Assessment:** Overall, Standard One has achieved its goal of increasing the level of primary care spend by 1% annually to build and expand primary care infrastructure. Insurers and providers report that funds have been directed almost exclusively towards practice infrastructure development and expansion with some practices funding traditionally non-reimbursable activities. These investments appear to be creating the conditions to support the transformation process within CSI practices, as self-reported by the practices. In the early evaluation of the practices by RAND Corporation and Harvard University, the researchers found early indications that the participating practices were positively impacting patient care processes and quasi-outcomes for diabetes quality and Ambulatory Care-Sensitive Conditions (ACSC) emergency department use.<sup>17</sup> What remains uncertain is whether the funding has been sufficient to support total practice transformation. Participating practices and the employer representative expressed the concern that the current level of support was not sufficient to support total practice transformation. More importantly, it is also unclear whether the increased investment has patient quality of care and quality and cost outcomes. Limited utilization data does not clearly impact an effect through 2011 and 2012, the year depending on the measure.

Two insurers cautioned that the requirement to increase PCP support without raising premiums has meant a reduction in specialty support, which has gotten the attention of the Rhode Island Medical Society and could lead to a future backlash. Their suggestion is to broaden the scope of the Primary Care Spend standard to include specialists who are efficient and support CSI practices. Relatedly, all insurers and both major health care systems expressed a concern that this standard and the Hospital Contracting standard are oriented to historical delivery system operation and are not sufficiently oriented to an anticipated future structure of health care providers operating across specialties in integrated risk-bearing organizations.

In the January 11, 2013 guidance on Primary Care Spend, the OHIC Commissioner made two key changes in his approach to specifying allowable primary care spending. First, he was more directive than in previous guidance memos, specifically requiring insurers to allocate primary care payments to non-fee-for-service activities, support of CSI and support of CurrentCare. Second, he listed four new categories of spending that were permissible areas of support to meet the Primary Care Spend targets. In response to stakeholder feedback, two of the

---

<sup>17</sup> Presentation by Meredith Rosenthal, Ph.D., to the CSI Steering Committee, entitled "Year 2 Evaluation Results: CSI Rhode Island", July 13, 2012.

categories allow insurers to spend funds that build PCP capacity that will enable primary care practices to transition into risk-bearing entities. Funds spend in any other category will not be recognized as meeting the insurer's obligation to Primary Care Spend obligation. Finally, the guidance memo prohibited insurers from pre-paying performance-based primary care incentive payments

These new requirements continue to support the broad adoption of medical home transformation, building on the strong CSI foundation and encouraging insurer-specific medical home program development that is consistent with CSI. In light of the impact that CSI has had on the marketplace, continuing this support of medical homes by the insurers is essential to continue the transformation momentum.

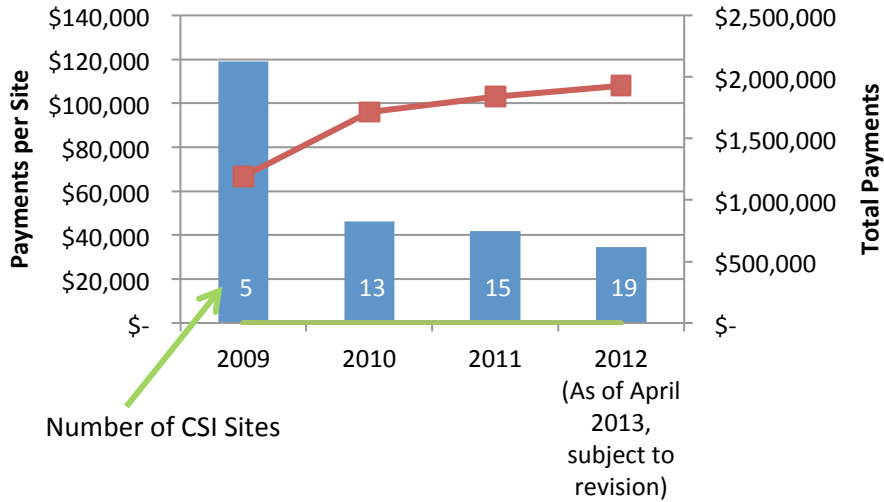
By allowing insurers to support primary care capacity development to support performance risk assumption that is starting to occur in the marketplace, OHIC is modernizing the Affordability Standards. By expanding the areas of allowable spending, the Affordability Standards will be responsive to the new type of needs that primary care practices face as payment moves to performance based methodologies. Moreover, by keeping up with trends in the marketplace, the Affordability Standards will avoid becoming a hindrance rather than a catalyst for transformation. Bailit has outlined several additional ways in which the Affordability Standards can continue to support health care transformation.

### **Standard Two: Spread the Adoption of the Patient-Centered Medical Home**

Affordability Standard Two specifies that insurers may support medical home adoption in two distinct, but related ways. First, they may support Rhode Island's Chronic Care Sustainability Initiative (CSI), an all-insurer-supported medical home transformation program, established by OHIC in 2009. Second, they may initiate and sustain their own medical home initiative, which both BCBSRI and United have done.

All three Rhode Island health insurers have provided on-going support to CSI practices. The following graph shows the growth in the number of participating CSI practices, the growth in total CSI funding by the insurers and the weighted average payment per site between 2009 and 2012. The average payment per site shows a large infusion of support at the level of \$120,000 per site in 2009 at the inception of the program. This support has leveled off to around \$40,000 per site in 2010 and 2011. The 2012 number is slightly lower which could be due to incomplete claim run-out,

## # of CSI Sites, CSI Weighted Average Payment/Site and Total Insurer Payments



In addition to supporting CSI, BCBSRI and United have pursued their own medical home initiatives with practices not participating in CSI. Based on information provided by BCBSRI, the following chart summarizes the total number of practices and physicians who are associated with medical home transformation. United did not file comparable information in its 4-15-13 quarterly Primary Care Spend submission, so Bailit was not able to include its insurer-specific data in this chart. However, all insurers submitted comparable data regarding their support of CSI, which re included in the data below.

CSI and BCBSRI-specific Medical Home Initiative				
CSI All Insurers	2009	2010	2011	2012
Number of Sites	5	13	16	19
Number of Providers	29	75	78	112
\$ Paid in PMPM Incentives	\$ 906,053	\$ 1,212,310	\$ 1,468,904	\$ 1,756,467
\$ Paid for Nurse Case Manager	\$ 284,919	\$ 460,838	\$ 280,308	\$ 150,639
Project Management Payments	\$ -	\$ 43,424	\$ 91,283	\$ 18,200
Total	\$ 1,190,972	\$ 1,716,572	\$ 1,840,495	\$ 1,925,306
BCBSRI-Specific Medical Home Initiative		2010	2011	2012
Number of Sites		42	67	75
Number of Providers		174	280	290
\$ Paid		\$ 4,807,897	\$ 5,202,336	\$ 9,838,740
<b>TOTAL MEDICAL HOME</b>	<b>\$1,190,972</b>	<b>\$6,524,469</b>	<b>\$7,042,831</b>	<b>\$11,764,046</b>

CSI and BCBSRI-specific Medical Home Initiative				
SUPPORT				

The data document a steady and consistent growth in the number of practices participating in CSI or insurer-specific medical home initiatives since 2009.

Based on an estimated 1000 PCPs in Rhode Island, 402 or 40% are associated with practices in some stage of medical home transformation. Should CSI and insurer-specific programs continue to expand, at some point a “tipping point” will be reached at which time significant change in practice dynamics across the state will start to become evident in insurer-wide utilization and cost data.

Both practices and insurers are currently reporting seeing transformational changes within practices participating in CSI. All of those interviewed believe that the Affordability Standards have had a direct impact on moving medical home transformation in Rhode Island forward. One major Rhode Island insurer believes that the OHIC Medical Home standards were adapted from work it was already doing, but acknowledged that OHIC’s Standards have resulted in quicker adoption by other practices and insurers, accelerating the change. Other insurers concurred that having a single model facilitated spread across practices more quickly. Importantly, one provider believes that his organization is proving that the medical home can be successfully implemented in small practices.

Providers universally identified the need for more infrastructure and medical home skills training as the key roadblocks to fully transforming into a medical home. One practice leader estimated that his practice was 20% to 30% towards being a medical home. Other limitations noted by one or more practices included:

- limited access to behavioral health services;
- need for more access to pharmacists’ time. (One practice reported that the local hospital was donating pharmacist time one half day per week, and that amount was insufficient.);
- more nurse care manager resources;
- more quality analysts to run, analyze and distribute reports;
- a paucity of quality metrics being collected and analyzed, and
- continual need to educate staff members on new roles and responsibilities.

### **Bailit’s Assessment**

This standard is considered by all stakeholders to have been a “game changer” in Rhode Island. Although one insurer had begun supporting medical home transformation, CSI unified all insurers behind a single payment and practice redesign model and started stakeholders to think and talk on a system level. With OHIC requiring insurer-specific medical home initiatives to be consistent with CSI, it also provided a framework for the insurers to pursue their own medical home initiatives, enabling a more rapid expansion of the model throughout Rhode Island practices. By having a common program structure, Tufts reported being able to integrate into the state initiatives more quickly than without a common structure, further aligning insurer initiatives.

It is too early to say definitively that the end goal of promoting medical homes in order to increase access and reduce costs has been achieved. A formal assessment funded by the Commonwealth Fund and conducted on behalf of OHIC looked at two years of pre and post-CSI data. Meredith Rosenthal, Ph.D., the principal investigator, was able to develop an early impression that the participating practices were positively impacting patient care processes and quasi-outcomes for diabetes quality and ambulatory care-sensitive conditions emergency department use.<sup>18</sup>

As noted above, CSI is relatively small and when considering BCBSRI's own medical home initiative, approximately 40% of Rhode Island PCPs are involved in a medical home initiative. To bring about the desired transformation envisioned by the Affordability Standards, support for medical homes must be significantly expanded.

Stakeholders also expressed an interest in having the payment model change. Providers are seeking support for applying the NCQA recognition, for better behavioral health integration, and ways to have practices that have completed the transformation to be supported. Insurers expressed interest in having the model move away from prospective per-member-per-month payments to payments for outcomes. Both providers and insurers raised questions about how to support smaller practices in the transformation process. A decision to extend CSI support beyond 2014 provides OHIC with an opportunity to convene a group of key stakeholders to address how the payment model should be changed.

### **Standard Three: Support CurrentCare**

This standard requires insurers to provide financial support to *CurrentCare*, the Rhode Island health information exchange (HIE). This standard was originally structured to require insurers to support the adoption of electronic medical records within physician offices, but was changed in 2012 to the current requirement. In an October 21, 2012 memo to the Health Insurance Advisory Council, OHIC provided the following rationale for the change:

- Take-up among provider of the EMR incentives offered by commercial health insurers has not been robust.
- Significant EMR incentives are now available through the Medicare and Medicaid Electronic Health Records (EHR) Incentive Programs. Eligible providers can receive up to \$44,000 through the Medicare EHR Incentive Program (as of 2011) and up to \$63,750 through the Medicaid EHR Incentive Program (as of 2012).
- *CurrentCare*, Rhode Island's health information exchange (not to be confused with the Rhode Island Health Benefits Exchange), is a secure electronic system which will allow doctors and other care givers immediate access to a patient's up-to-date health information in order to provide the best possible and most comprehensive care. OHIC's view is that *CurrentCare* now represents a statewide health information technology investment with greater potential to contribute to achieving HIAC's goal of reducing medical expense trend while making a positive impact on health outcomes.

---

<sup>18</sup> Presentation by Meredith Rosenthal, Ph.D., to the CSI Steering Committee, entitled "Year 2 Evaluation Results: CSI Rhode Island", July 13, 2012.

Those interviewed strongly support the change in focus of this standard, believing that the development of a HIE will be beneficial to Rhode Island patients and providers as an important piece of infrastructure to improve communications across the care continuum.

### **Bailit's Assessment**

Support for *CurrentCare* does not directly financially benefit primary care practices and, therefore, does not meet the initial intent of the Primary Care Spend standard. However, given the scarcity of health care dollars, OHIC's decision to shift insurer funding to a state-wide IT project where their funding can potentially have a more significant impact than with EHR investment is reasonable. The original effort to support EMR development within practices appears to have been less effective than anticipated due to the cost of implementing an EMR system compared with the level of funding available from the insurers to support EMR adoption. Moreover, practices are receiving support from the Rhode Island Regional Extension Center (RI REC) as part of a nation-wide effort to bring EMRs into physician practices.

Supporting a statewide HIE has the potential for improving cross-provider communications for practices with EHRs. With the Rhode Island Regional Extension Center (REC)'s efforts to increase EMR adoption by primary and specialty practices, *CurrentCare's* availability to providers will eventually be broad. However, *CurrentCare's* ultimate value will depend on the number of patients who agree to have their medical records shared via *CurrentCare*, which is currently around 33% of Rhode Island patients according to a Rhode Island QI representative.

Insurer support is believed by stakeholders to be essential for the ultimate success of the initiative. As a matter of public policy, supporting the development of a state health information exchange by recognizing these payments as Primary Care Spend is warranted under the Affordability Standards so long as these payments do not become disproportionately high compared to direct payments to PCPs. While the payments will not directly financially support primary care practices, they will, in time, functionally support the practices' ability to care for their patients.

### **Standard Four: Hospital Contracting Standard:**

The current configuration of the Hospital Contracting Standard, which Bailit used to evaluate insurer compliance, requires insurers to meet the following six conditions when contracting with hospitals:

1. **Units of Service:** Utilize unit of service payment methodologies for both inpatient and hospital outpatient services that realign payment to provide incentives for efficient use of health services, and are derived from nationally utilized payment practices other than fee-for-service, e.g. inpatient Diagnosis Related Groupings (DRGs) and outpatient Ambulatory Payment Classifications (APCs) in a form substantially derived from CMS.
2. **Rate of Increase:** Limit average annual effective rates of price increase for both inpatient and outpatient services to a weighted amount equal to or less than the CMS National Prospective Payment System Hospital Input Price Index, for all contractual and optional years covered by the contract.

3. **Quality Incentives:** Provide the opportunity for hospitals to increase their total annual revenue for commercially insured enrollment under the contract over the previous contract year by attaining mutually agreed-to performance levels for all or a subset of measures in the CMS Hospital Value-Based Purchasing Program for Medicare worth at least 2% of revenue. The 2% floor was subsequently removed by OHIC for all contracts signed after October 2012.
4. **Administrative Simplification:** Include terms that define the parties' mutual obligations for greater administrative efficiencies, such as improvements in claims and eligibility verification processes, and identify commitments on the part of each.
5. **Care Coordination:** Include terms that require the hospital to measure and self-report to the designated QIO in a format and on a schedule determined by the QIO its performance for nine specified best practices that have been documented to lead to improved quality of inpatient discharges and transitions of care.
6. **Transparency:** Include terms that relinquish the right of either party to contest the public release of the any and all of these five specific terms by state officials or the participating parties to the agreement; provided that the issuer or other affected party may request the Commissioner to maintain specific contract terms or portions thereof as confidential, if properly supported with legal and factual analysis justifying confidentiality.

This section will examine the impact the standard has had on hospital-insurer relationships, as well as the extent to which each element of the hospital contracting standard has been met. Particular focus will be on the extent to which hospital payments use payment reform methodologies that emphasize quality and efficiency, rather than fee-for-service methodologies.

#### *Altered Negotiation Dynamics*

The inflation cap coupled with the requirement to include quality-based initiatives has had a profound impact on insurer - hospital relationships for two of the three major insurers. BCBSRI and United reported that prior to OHIC implementing the cap, they possessed very little leverage over larger hospitals to curb rate increases. For them, therefore, the cap has shifted negotiating leverage to the insurers. The insurers praised this result. Tufts, a relatively new entrant into the market, found the cap helpful in negotiations, but did not find that it changed the nature of the relationship with its provider network.

Not surprisingly, all the hospital administrators felt that limiting hospital rate increases were very effective at reducing hospital reimbursement rates, but were unfair. The lower paid hospitals believed that the cap on increases codified the unsupportable payment differentials between the hospitals and argued for payment transparency. The large hospital systems argued that payments should be tied to outcomes and not arbitrarily limited to a set percentage or external index. The future-oriented message from hospitals was that focusing on hospital unit payments was "old school" and that in order for true payment reform to occur, OHIC needed to promote accountable care organizations that are capable of accepting risk.

#### *Units of Service*

The standard requires insurers to utilize unit-of-service payment methodologies for both inpatient and hospital outpatient services that realign payment to provide incentives for efficient use of health services, and are derived from nationally utilized payment practices other



than fee for service, such as, inpatient Diagnosis Related Groupings (DRGs) and outpatient Ambulatory Payment Classifications (APCs) in a form substantially derived from CMS.

In reviewing the reimbursement methodologies being implemented with hospitals there are several observations to be noted.

First, payment methodologies that promote efficiency are taking hold in Rhode Island, primarily in the form of DRGs and APCs. All three major insurers have the capability to administer DRGs and APCs. BCBSRI appears to be more aggressive in moving hospitals to DRGs and APCs than is United, principally because it just recently re-contracted with most of its hospital network. Tufts reported that it is moving to DRGs and APCs for its large hospitals. It will not be implementing these payment methodologies with smaller hospitals unless and until volume increases with those hospitals. All but one of the hospitals interviewed believed that the Hospital Contracting Standard has encouraged insurers and hospital to seriously consider payment methodologies that reward efficiency more quickly than would have occurred without them.

Second, providers and insurers are moving beyond efficiency-oriented payment methodologies to payment reform that promotes both efficiency and quality, principally shared savings programs. One hospital system pointed to the recently signing of a letter of agreement to develop a five-year shared savings reimbursement model with a major Rhode Island insurer as evidence of the impact of the standard. However, another major hospital system that was already moving in the direction of shared savings acknowledged that the Affordability Standards may have accelerated adoption of shared savings programs slightly, but believed that macro spending concerns would have moved the hospital there anyway.

United is further advanced in negotiating and administering ACO contracts, in part because of its ability to draw on national experience. However, BCBSRI is currently committed to negotiating a new five-year contract with Care New England which will include a global payment arrangement and DRG and APC hospital payments. BCBSRI anticipates having some component of an alternative payment methodology in place with Care New England hospitals by the end of 2013.

Third, Lifespan acute care hospitals appear to be operating under payment methodologies that support efficiency or quality to a greater extent than other hospitals. Both of the major insurers reimburse most Lifespan services under payment methodologies that support efficiency. Beginning in January 2013, BCBSRI implemented DRGs and APCs at all Lifespan hospitals, except Bradley for which DRGs and APCs are not applicable. The contract also includes a shared savings program that is focused on reducing readmissions for two specific procedures. Lifespan's interest in alternative payment methodologies is manifested in its new ACO agreement with United. Under this agreement Lifespan has an opportunity to share savings equally with United if actual costs come in below expected costs during the measurement period and quality targets are achieved. There is no cap on the amount of savings to be earned. It should be noted that Lifespan assumes no downside risk for exceeding expected spending. There are many who believe that true reform of care delivery cannot occur until providers assume a meaningful amount of downside performance risk.

Fourth, the hospitals that are financially vulnerable have older contracts that are being carried forward until their long-term viability is clearer.

Fifth, mental health facilities are less likely than acute care hospitals to be reimbursed under alternative payment methodologies.

The table below provides an estimate as to what percentage of total payments to each hospital currently comes under alternative payment methodologies, which in this chart are defined within the Rhode Island context as DRGs, APC and case rates. This estimate is based on the contracts in place at the time of Bailit’s contract audit and on the statewide market share of the insurers. The estimate will be overstated because some insurers use multiple methodologies, only some of which emphasize efficiency, and among which we cannot allocate payments. Therefore, these percentages can only be used as a general directional indication. It is also important to note that the level of payment provided under the alternative payment methodologies was not evaluated, making it impossible to assess payment level impact on provider behavior.

<b>Estimate of Percent of Inpatient and Outpatient Payments using DRG, APC, Case Rates by Hospital</b>	
<b>Name of Hospital</b>	<b>Estimated percentage of total payments under alternative payment methodologies</b>
Landmark Hospital • Inpatient • Outpatient	• 40% • 0%
Westerly • Inpatient • Outpatient	• 60% • 30%
St Joseph’s • Inpatient • Outpatient	• 60% • 30%
Roger Williams • Inpatient • Outpatient	• 90% • 30%
Memorial • Inpatient • Outpatient	• 60% • 30%
Care New England (Acute Hospitals) • Inpatient • Outpatient	• 10% • 30%
Care New England (Non-acute Hospital) • Inpatient • Outpatient	• 0% • 0%
Lifespan (Acute Hospitals) • Inpatient • Outpatient	• 90% • 90%
Lifespan (Non-acute Hospitals) • Inpatient • Outpatient	• 0% • 0%

The three largest insurers were asked to submit financial information for calendar year 2012, identifying the amount of spending under different payment reform methodologies. BCBSRI and Tufts reported data, but United did not submit complete data by OHIC’s deadline.

The combined data for BCBSRI and Tufts indicated that approximately 20% of payments are made under some form of payment reform methodology. The majority of these payments (18%) are fee-for-service arrangements plus pay-for-performance programs. Another one percent (1%) was paid under fully capitated payments arrangements with quality of care components, and one percent (1%) fee-for-service-based shared savings programs with quality of care components.

Tufts commented that in 2012 the insurer expanded its pay-for-performance (P4P) arrangements beyond the three physician groups that were participating in 2010 to include hospital systems as well. BCBSRI noted that its payment reform methodology can generally be categorized as FFS plus P4P.

### **Bailit's Assessment**

Although payment reform is taking hold in Rhode Island, it is still very modest. The payment reform methodologies for hospital payments are DRGs, which have been used by Medicare for decades and APCs, which were implemented for Medicare in 2000. The case rate methodology used by one insurer is limited to a global physician payment under which the cost of an inpatient surgical procedure (surgery through post-op) is included in one physician payment and does not include an entire episode of care. Other payment reform methodologies are predominantly structured as pay-for-performance programs. Risk-sharing contracts are new to Rhode Island and include at this point in time only upside risk for the providers. OHIC has an opportunity to advance payment reform by structuring the next generation of Standards guidance to support further coordination of care along a continuum of care, with stronger incentives to coordinate care delivery across providers.

### ***Rate of Increase***

The standard requires the insurers to limit average annual effective rates of price increase for both inpatient and outpatient services to a weighted amount equal to or less than the CMS National Prospective Payment System Hospital Input Price Index, for all contractual and optional years covered by the contract.

A review of all hospital contracts indicated that with rare exception all contracts limited rate increases to the CMS index. One insurer used the base year CMS index throughout the term of the contract, rather than changing the rate of increase annually as the CMS index changed. The insurer adopted this approach on the belief that the index was probably going up in the future; therefore, specifying the base year percentage would result in additional savings.

Other insurers specifically stated in the contract that the increase was limited to the CMS index. The Landmark contract is the only one in which none of the insurers included the limitation. In all cases the Landmark contract was an old one with insurers having no plans to renegotiate it until the anticipate sale of the hospital to a Connecticut-based hospital system was completed. The limitation on increases is also missing from the United contract with South County. United described negotiating a higher guaranteed rate of increase as a contracting necessity.

<p style="text-align: center;"><b>Hospital Contracts Including Limitation on Rate Increases Equal to the CMS Index</b></p>
--

	<b>BCBSRI</b>	<b>United</b>	<b>Tufts</b>
Landmark Hospital	No	No	No
Westerly	Yes	Yes	Yes
St. Joseph's	Yes	Yes	Yes
Roger Williams	Yes	Yes	Yes
Memorial	Yes	Yes	Yes
CNE Women and Infants	Yes	Yes	Yes
CNE Kent	Yes	Yes	Yes
CNE Butler	Yes	No	Yes
South County	Yes	No	Yes
Lifespan: Bradley	Yes	Yes	Yes
Lifespan: Newport	Yes	Yes	Yes
Lifespan: RI Hospital	Yes	Yes	Yes
Lifespan: Hasbro Children's	Yes	Yes	Yes
Lifespan: Miriam Hospital	Yes	Yes	Yes

### **Bailit's Assessment**

Limiting hospital rate increases has been very effective in changing the insurer-hospital negotiating dynamics. However, the current structure of the Rate of Increase and the Quality Incentive requirements and how they are being implemented raises two concerns.

First, the Standard does not place a maximum cap on increases that relate to quality, thereby undermining the policy of OHIC to limit hospital rate increases. While, insurers report being able to negotiate lower rates of increases with hospitals because of the Standard, a review of the contracts suggested otherwise in some cases. For several hospitals United seemed to use the quality incentive to significantly increase the level of reimburse above the CMS Index and above the general rate of inflation. While it may be desirable to link more funding to quality performance, it is concerning that the two hospital contracting requirements can function together to generate significant rate increases and undermine any rate mitigation impact of the CMS Index. Moreover, most insurers pay the quality payments prospectively and then recoup payments if performance goals are not met, which may decrease the motivational power of the quality incentives.

BCBSRI generally negotiated a relatively low cap on the total rate of increase year-over-year, but it was always in excess of the CMS Index. Once a total increase was negotiated with the hospital, BCBSRI would further indicate what percentage of the increased payments was tied to the Index and to the quality incentive. For example, if a 3.5% increase were negotiated and the CMS Index increased 0.5% from the prior year, 0.5% of the increase would be used to match the CMS Index rate and the remaining 3% of new funding would be for quality incentives. If the previous year's contract allocated 5% for quality payments, the additional 3% would bring the total percentage of hospital revenue tied to quality payments to 8% for the new year.

Second, rolling quality incentive payments into rate increases is more inflationary than paying lump sum payments. Because both BCBSRI and United pay quality incentives prospectively in the form of rate increases, funding directed towards quality incentives become part of the hospital's base payment that is then the payment level that is increased in subsequent years through negotiated rate increases. A lump sum payment would be less inflationary because it does not become part of the rate structure, thus keeping the CMS Index as a true cap on rate

increases. By structuring quality payments as part of the rate increase, the rate increase cap is being circumvented.

In considering future adjustments to the hospital contracting standards, OHIC has an opportunity to limit the total rate increase for hospital services. However, limiting hospital unit pricing is likely a short-term solution that needs to be partnered with a strategy to recognize movement of major hospital systems into population-based risk contracts.

### *Quality Incentives*

The standard, as outlined in a July 2010 communications from OHIC<sup>19</sup>, requires that insurers meet two contracting requirements: include a quality incentive worth at least 2% of contract revenue and utilize quality measures from the CMS Hospital Value-Based Purchasing Program for Medicare (CMS Core Measure set) in the incentive. The standard was changed in October 2012<sup>20</sup> to remove the requirement that quality incentives be work at least 2% of contract revenue and to specify that prospective payments were not permitted, while allowing interim payments commensurate with the hospital's performance. In assessing contract compliance, contracts effective prior to November 2012 were evaluated under the terms outlined in the July 2010 communications, and those executed later than November 2012 were evaluated under the October 2012 communications.

*Inclusion of Quality Measures in Contracts.* With the exception of the Landmark contracts, all hospital contracts included quality performance incentives. The United and Tufts contracts include program details, such as measures and performance targets that must be achieved to earn quality bonus funds. BCBSRI contracts include a requirement that the hospitals participate in the insurer's quality program. Program parameters are set annually and detailed in a separate document that is shared with each hospital, but are not defined within the contract.

*Level of Funding.* The level of funding linked to quality performance varied widely among the hospital contracts. For those hospital contracts subject to the July 2010 standards, which required a quality incentive equal to at least 2% of contract revenue, with the exception of the following contracts, the quality payments met or exceeded the two-percent minimum specified in the OHIC regulation.

- BCBSRI: Westerly and Roger Williams (2012 bonus)
- Tufts Health Plan: South County, and Lifespan (2012 bonus)

The following contracts are subject to the October 2012 standards, which removed the 2% requirement and limited the use of prospective quality payments:

- BCBSRI: Lifespan contract effective January 1, 2013
- Tufts Health Plan: Care New England contract effective January 1, 2013 and Memorial Hospital contract effective July 1, 2013
- United Healthcare: Care New England contract effective January 1, 2013

---

<sup>19</sup> See "Office of Health Insurance Commissioner, July 2010 Fate Factor Decision, Additional Conditions." Memo from Christopher F. Koller, Rhode Island Health Insurance Commissioner, dated July 2010.

<sup>20</sup> See "The Affordability Standards: A Summary," published by the Rhode Island Office of the Health Insurance Commissioner and dated October 2012.

A review of contract terms indicates that the quality incentives varied widely, with some under 2% and others over 2%. BCBSRI negotiated a total percentage increase. Depending on the amount of the CMS Index for the year, which was attributed to the increase first, the new monies applied to the quality incentive could be less than 2%. However, when looking at total funds available for quality incentives, the amounts exceeded 2% of total contract revenue.

*Method of Payment.* As discussed above, both United and BCBSRI calculated quality payments as a percentage increase in payment rates. In contrast, Tufts generally made quality payments in a lump sum amount. All of the insurers frequently made quality payments in advance and then recouped overpayments through a settlement process at the end of the year if all quality targets were not attained. BCBSRI also negotiated a maximum percentage by which both the quality bonus and the index could increase. It, therefore, if necessary, can adjust the percentage available for quality payments so that the total increase stays within the negotiated cap. There was no discernible difference after the October 2012 limitation of prospective payment of incentives was instituted.

*Measures Included in Contract.* The measures included in the contracts generally promote more efficient and effective delivery of care. For example, many contracts link quality incentives to adoption of the safe transitions program developed by the Rhode Island QIO, Healthcentric Advisors. As required by the Standard, all contracts included some CMS core measures. Roger Williams, however, does not have quality measures negotiated with Tufts for 2013 and 2014.

BCBSRI appears to have tailored measures for different hospitals within a single system, whereas United and Tufts applied the same measures to the system as a whole. There appears to be some effort by many of the hospitals to have consistent quality measures across insurers. Depending on the number of measures included in the contract, the measures across insurers may align, but the weight given them will differ. Most of the measures are process, rather than outcome, measures.

*Impact of Standard on Hospitals.* Two insurers believe that the requirement to include quality incentives has resulted in a noticeable cultural shift within hospitals, which the insurers were not able to achieve without this Affordability Standard. One insurer described several hospitals' prior quality initiatives as "unsophisticated," focusing on work process requirements dictated by Joint Commission accreditation standards, rather than outcomes. Pointing to this standard, the insurers have shifted the focus to care outcomes (e.g., reducing infection rates, readmission rates, etc.). The one insurer that indicated that it had been working with hospitals around care outcomes previously indicated that the Hospital Contracting Standard has sped up the process of adoption and change on the part of the hospitals. The insurers agreed that the funding targeted for quality was sufficient to change behavior within the hospitals. One insurer, however, expressed concern that the index plus the minimum of two percent for quality has become a starting point on the part of the hospitals as they negotiate with the insurers. This interpretation of the Standards appears to further undermine OHIC's goal of slowing the rate of hospital rate increases.

The impact of this Affordability Standard has been recognized by the hospitals. One hospital reported that the initiation of quality metrics tied to payment by one of Rhode Island's major insurers has had a direct impact of forcing the hospital to take a more aggressive stance regarding quality. Another hospital reported that the standards reinforced the quality work it had already started. For example, the insurers' including transitions-of-care requirements in their quality standards and payment methodology has raised the urgency to develop a

transitions-of-care protocol. One hospital reported placing a pharmacist on the floors and in the Emergency Department to do medication reconciliations, which has resulted in a reduction in rates of readmission of surgical and medical patients. The detailed knowledge that the administrators had of the quality measures suggested that quality implementation details are within the purview of top hospital administrators.

The table below summarizes whether the contract provisions regarding funding levels associated with achieving quality targets and the associated quality measures meet the OHIC requirements.

<b>Hospital Contracts Including Quality Funding Levels and Quality Targets that Meet the OHIC Requirements</b>			
	<b>BCBSRI</b>	<b>United</b>	<b>Tufts</b>
Landmark Hospital <ul style="list-style-type: none"> <li>• Quality Incentive</li> <li>• CMS Core Measures</li> </ul>	<ul style="list-style-type: none"> <li>• No</li> <li>• No</li> </ul>	<ul style="list-style-type: none"> <li>• No</li> <li>• No</li> </ul>	<ul style="list-style-type: none"> <li>• No</li> <li>• No</li> </ul>
Westerly <ul style="list-style-type: none"> <li>• Quality Incentive</li> <li>• CMS Core Measures</li> </ul>	<ul style="list-style-type: none"> <li>• No</li> <li>• Yes</li> </ul>	<ul style="list-style-type: none"> <li>• Yes</li> <li>• Yes</li> </ul>	<ul style="list-style-type: none"> <li>• Yes</li> <li>• Yes</li> </ul>
St. Joseph's <ul style="list-style-type: none"> <li>• Quality Incentive</li> <li>• CMS Core Measures</li> </ul>	<ul style="list-style-type: none"> <li>• Yes</li> <li>• Yes</li> </ul>	<ul style="list-style-type: none"> <li>• Yes</li> <li>• Yes</li> </ul>	<ul style="list-style-type: none"> <li>• Yes</li> <li>• Yes</li> </ul>
Roger Williams <ul style="list-style-type: none"> <li>• Quality Incentive</li> <li>• CMS Core Measures</li> </ul>	<ul style="list-style-type: none"> <li>• No (2012) Yes ('13/14)</li> <li>• Yes</li> </ul>	<ul style="list-style-type: none"> <li>• Yes</li> <li>• Yes</li> </ul>	<ul style="list-style-type: none"> <li>• Yes</li> <li>• Yes (2012) 2013/14 QI measures in negotiations</li> </ul>
Memorial <ul style="list-style-type: none"> <li>• Quality Incentive</li> <li>• CMS Core Measures</li> </ul>	<ul style="list-style-type: none"> <li>• Yes</li> <li>• Yes</li> </ul>	<ul style="list-style-type: none"> <li>• Yes</li> <li>• Yes</li> </ul>	<ul style="list-style-type: none"> <li>• Yes</li> <li>• Yes</li> </ul>
Care New England Acute Care Hospitals <ul style="list-style-type: none"> <li>• Quality Incentive</li> <li>• CMS Core Measures</li> </ul>	<ul style="list-style-type: none"> <li>• Yes</li> <li>• Yes</li> </ul>	<ul style="list-style-type: none"> <li>• Yes</li> <li>• Yes</li> </ul>	<ul style="list-style-type: none"> <li>• No</li> <li>• Yes</li> </ul>
Care New England Non-Acute Care Hospitals <ul style="list-style-type: none"> <li>• Quality Incentive</li> <li>• CMS Core Measures</li> </ul>	<ul style="list-style-type: none"> <li>• Yes</li> <li>• Yes</li> </ul>	<ul style="list-style-type: none"> <li>• No</li> <li>• No (QI measures in negotiation)</li> </ul>	<ul style="list-style-type: none"> <li>• No</li> <li>• Yes</li> </ul>
South County <ul style="list-style-type: none"> <li>• Quality Incentive</li> <li>• CMS Core Measures</li> </ul>	<ul style="list-style-type: none"> <li>• Yes</li> <li>• Yes</li> </ul>	<ul style="list-style-type: none"> <li>• Yes</li> <li>• Yes</li> </ul>	<ul style="list-style-type: none"> <li>• No</li> <li>• Yes</li> </ul>
Lifespan Acute Care Hospitals <ul style="list-style-type: none"> <li>• Quality Incentive</li> <li>• CMS Core Measures</li> </ul>	<ul style="list-style-type: none"> <li>• Yes</li> <li>• Yes</li> </ul>	<ul style="list-style-type: none"> <li>• Yes</li> <li>• Yes</li> </ul>	<ul style="list-style-type: none"> <li>• No (2012) Yes (2013)</li> <li>• Yes</li> </ul>
Lifespan Non-Acute Care Hospitals <ul style="list-style-type: none"> <li>• Quality Incentive</li> <li>• CMS Core Measures</li> </ul>	<ul style="list-style-type: none"> <li>• Yes</li> <li>• Yes</li> </ul>	<ul style="list-style-type: none"> <li>• Yes</li> <li>• Yes</li> </ul>	<ul style="list-style-type: none"> <li>• No (2012) Yes (2013)</li> <li>• Yes</li> </ul>

## **Bailit's Assessment**

The linking of the CMS Index and the quality bonus requirement appear to be resulting in rate increases for some hospitals that are greater than anticipated by the Affordability Standards. As several insurers have suggested, the CMS Index plus 2% is viewed as a starting point for negotiating rate increases. OHIC may want to consider setting a total cap on hospital rate increases that insurers may negotiate in conjunction with specifying the percentage of revenue that must be earned through quality bonuses. Moreover, OHIC may want to consider requiring quality incentives to be paid in a lump sum, rather than as part of a rate increase in order to dampen the inflationary impact of the quality incentive payments when treated as part of a rate increase.

The insurers appear to have seized upon this requirement to push quality initiatives forward more aggressively than if the standard was not in place. The insurers are setting performance targets, which for the larger hospitals and for the multi-hospital systems generally increase annually. Both insurers and hospitals believe that this standard has started to have a significant influence on the hospital culture around quality.

Moreover, adding the quality bonus into the fee-for-service rate may hide the significance of the payments more than if they were paid in a lump sum. Insurers, however, report that the quality payments do have the attention of the hospitals.

Removing the 2% floor on quality incentive payments did not appear to noticeably impact the level of incentives negotiated by the parties because incentive payments before October 2012 and after 2012 were above and below the 2% floor. For example, the contract with a quality incentive below 2% after October 2012 was negotiated by an insurer that had negotiated a quality incentive greater than 2% at another hospital. Other contracts negotiated after the October 2012 change had incentives that exceeded 2% and some were below. Nevertheless, removing the 2% requirement did provide increased flexibility for the insurers.

Finally, since Bailit did not assess the effectiveness of the quality incentives, OHIC may want to consider collaborating with the insurers to develop a process of measuring their effectiveness.

### ***Administrative Simplification***

The standards require insurers to include terms that define the parties' mutual obligations for achieving greater administrative efficiencies, such as improvements in claims and eligibility verification processes, and identify shared commitments.

Compliance with this requirement has not been consistent. BCBSRI has been the most consistent in including this requirement in its contracts. The one BCBSRI contract without the language has not been re-negotiated since the inception of the requirement. The language is missing from three Tufts contracts. United included the language in only one of its contracts.

A representative from the Rhode Island Hospital Association reported that the hospitals did not find this standard to be effective because it is too difficult to address key administrative issues that affect all hospitals in a decentralized fashion. In response, HARI introduced the legislation which established the current administrative simplification initiative under OHIC.

The table below summarizes the status of insurer contracts with regard to meeting this requirement.



Summary of Contracts with Required Administrative Simplification Language			
	<b>BCBSRI</b>	<b>United</b>	<b>Tufts</b>
Landmark Hospital	No	No	No
Westerly	Yes	No	No
St. Joseph's	Yes	No	No
Roger Williams	Yes	No	Yes
Memorial	Yes	Yes	Yes
CNE Women and Infants	Yes	No	Yes
CNE Kent	Yes	No	Yes
CNE Butler	Yes	Yes	Yes
South County	Yes	No	Yes
Lifespan: Bradley	Yes	Yes	Yes
Lifespan: Newport	Yes	No	Yes
Lifespan: RI Hospital	Yes	No	Yes
Lifespan: Hasbro Children's	Yes	No	Yes
Lifespan: Miriam Hospital	Yes	No	Yes

### **Bailit's Assessment**

Based on stakeholder interviews, this requirement appears to have been successful. A common process that brings all key insurers and providers together to discuss shared concerns appears to be the preferred method for addressing administrative simplification issues. The work of the Administrative Simplification Taskforce has involved providers and insurers addressing very complex issues with the intent to find mutually satisfactory solutions. This appears to be a superior approach to that required in the Affordability Standards.

### **Care Coordination**

This standard requires insurers to include contract terms that require the hospital to measure and self-report to the designated Medicare QIO its performance with respect to nine specified best practices that have been documented to lead to improved quality of inpatient discharges and transitions of care.

BCBSRI is the only insurer that consistently included care coordination requirements in its contracts. Many of the insurers included establishing a Safe Transitions program as one of the quality measures without including the required care coordination language in the contract. The hospitals and insurers have adopted the Safe Transitions program developed by the Healthcentric Advisors as the care coordination initiative. That program includes most, but not all, of the nine requirements specified in the most recent statement of the care coordination requirement. Generally, the Safe Transitions program elements included in the contracts do not include the requirement that PCPs be invited to participate in end-of-life discussions during the hospital visit or that the patient receives effective education prior to discharge.

Summary of Contracts Containing Required Care Coordination Language			
	<b>BCBSRI</b>	<b>United</b>	<b>Tufts</b>
Landmark Hospital	No	No	No
Westerly	Yes	No	No
St. Joseph's	Yes	No	No
Roger Williams	Yes	No	No
Memorial	Yes	No	Yes

Summary of Contracts Containing Required Care Coordination Language			
	BCBSRI	United	Tufts
CNE Women and Infants	Yes	No	Yes
CNE Kent	Yes	No	Yes
CNE Butler	Yes	Yes	Yes
South County	Yes (older regulatory language)	No	No
Lifespan: Bradley	No	Yes	No
Lifespan: Newport	Yes (older regulatory language)	No	No
Lifespan: RI Hospital	Yes (older regulatory language)	No	No
Lifespan: Hasbro Children's	Yes (older regulatory language)	No	No
Lifespan: Miriam Hospital	Yes (older regulatory language))	No	No

### **Bailit's Assessment**

Compliance with this requirement has been poorer than for other hospital contracting requirements. However, in recent conversations Lynn Chase, Senior Program Administrator at Healthcentric Advisory, which is the entity implementing the Safe Transitions initiative, reported that hospital implementation is moving forward. Specifically, she indicated that on April 15, 2013 all 11 acute care hospitals for the first time submitted quarterly data (January through March, 2013) on their Safe Transitions programs. She further reported that the hospitals are at various stages in implementing the program with some in pilot stage and others preparing to roll out the initiative hospital-wide. Lynn has offered to share the results of the analysis of the data submitted when it is available later in the month. She emphasized that Healthcentric Advisors is working directly with each hospital to implement the best practices in a way that results in meaningful and effective care, and not a box checking exercise.

It is Bailit's impression that the hospitals are moving to implement Safe Transitions because it is included as a requirement within the hospital's quality bonus programs, rather than because care coordination requirements are specified separately in the contract with the insurer. OHIC has an opportunity to work more closely with Healthcentric Advisors by receiving their assessment of hospital activities and using that information in shaping Affordability Standard requirements. Bailit provides several specific suggestions in the Recommendation section below.

### ***Transparency***

This standard requires insurers to include terms that relinquish the right of either party to contest the public release of any and all of these five specific terms by state officials or the participating parties to the agreement; provided that the issuer or other affected party may request the Commissioner to maintain specific contract terms or portions thereof as confidential, if properly supported with legal and factual analysis justifying confidentiality.

Each of the Rhode Island insurers developed some standard language addressing transparency requirements. BCBSRI included language that closely tracked the regulatory language and included it in all but its Landmark Hospital contract. United includes general transparency

language that meets the intent of the requirement without using the specific regulatory language and has included the language in each of its contracts. Tufts Health Plan has developed language that permits disclosures if “compelled by the Rhode Island Office of the Health Insurance Commissioner,” but included the language in only a few of its contracts.

Summary of Compliance with the Transparency Language Requirement			
	<b>BCBSRI</b>	<b>United</b>	<b>Tufts</b>
Landmark Hospital	No	Yes	No
Westerly	Yes	Yes	No
St. Joseph’s	Yes	Yes	No
Roger Williams	Yes	Yes	Yes
Memorial	Yes	Yes	Yes
CNE Women and Infants	Yes	Yes	Yes
CNE Kent	Yes	Yes	Yes
CNE Butler	Yes	No	Yes
South County	Yes (older regulatory language)	Yes	Yes
Lifespan: Bradley	Yes	No	No
Lifespan: Newport	Yes	Yes	No
Lifespan: RI Hospital	Yes	Yes	No
Lifespan: Hasbro Children’s	Yes	Yes	No
Lifespan: Miriam Hospital	Yes	Yes	No

### **Bailit’s Assessment**

So long as OHIC intends to pursue issues associated with differentials in hospital payment levels, it will be important to maintain this requirement to allow the public disclosure of hospital payment rates by OHIC. The failure of Tufts to include this requirement in its contracts should be pursued.

### ***Self-Insured Accounts’ Support of the Affordability Standards***

As the graph below documents, the fully-insured account base is declining as the self-insured account base is increasing. Between 2005 and 2012, the percentage of fully-insured covered lives decreased from 66% of the market to 57%, representing a decline of 93,801 lives. Self-insured covered lives grew from 34% of the market to 43% of the market, adding 30,527 covered lives. Since the Commissioner’s authority is over an insurer’s fully-insured book of business, the decline in people who are fully insured raises the question of the long-term sustainability of the Affordability Standards as a source of funding for health care innovation to advance health insurance affordability. It also raises the related questions of what benefits self-insured accounts are realizing from the Affordability standards and whether any of the insurers are seeking financial support from self-insured accounts for Affordability Standard application.

In considering the impact of the Affordability Standards on self-insured accounts, it is important to consider how the insurers contract with their provider networks, how they are implementing the CSI-RI, and how the insurers charge costs back to self-insured accounts.

BCBSRI, United and Tufts report that they do not differentiate between self-insured and fully insured accounts in contracting with their provider networks. Therefore, the self-insured accounts are benefiting from all cost savings and quality improvement that the Hospital Contracting Standards are generating.

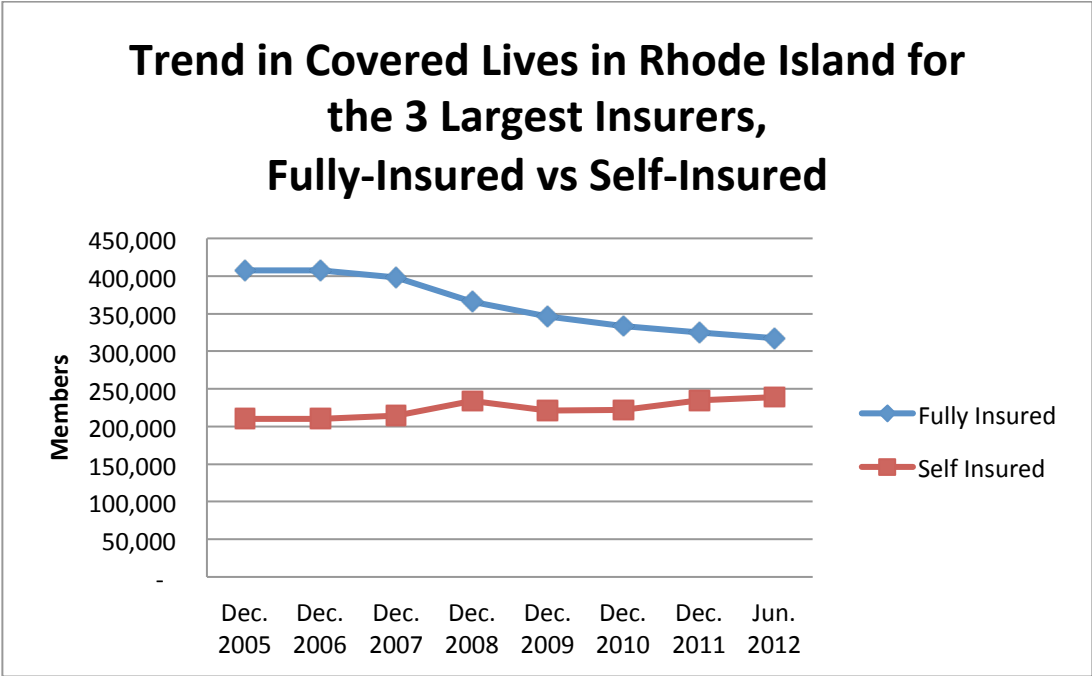
The Commissioner expected the insurers to include self-insured patients within the CSI attribution methodology. As a result, practices are receiving PMPM payments from insurers for self-insured patients, who arguably are benefiting from primary care practice transformation into medical homes. United indicated that at the time of contract renewal, it is amending all self-insured account contracts to require self-insured accounts to cover payments made by United that are outside of standard fee-for-service payments. A PMPM payment to medical home practices is an example of such payments. United estimates that currently over half of its Rhode Island self-insured contacts have been amended. Tufts reported that none of its self-insured accounts are funding any of these costs. BCBSRI did not provide the requested information.

With regard to other types of expenses that qualify for Primary Care Spend, such as support for *CurrentCare*, Tufts reported that no self-insured account is contributing to paying these costs. United also indicated these costs would be covered by its contract amendment. BCBSRI did not provide the requested information.

Based on this information, it appears that historically fully-insured accounts have been disproportionately funding the non-CSI Primary Care Spend costs. As discussed above, United is in the process of changing its self-insured contracts to cover non-fee schedule provider payments. Because of OHIC's statutory authority, the Commissioner's ability to directly impact self-insured accounts is limited. It would be possible for the Commissioner, as part of its rate review process, to obtain information regarding whether the premiums paid by fully insured accounts accurately reflect the proportionate cost for programs from which these covered lives are benefiting. Factors that the Commissioner might use to evaluate whether fully insured accounts are paying their fair share include:

- whether the insurer has developed and implemented billing codes for medical home activities that are not traditionally reimbursable, as care management, and
- whether insurers have amended self-insured account agreements to include funding the costs of those Affordability Standards from which they benefit.

The Commissioner could share the results of the data collection with insurers who are not spreading Affordability Standard costs to self-insured accounts and encourage them to do so.



**Unintended Consequences**

During the course of the interviews a few unintended consequences of the Affordability Standards were brought up by the interviewees and are summarized and discussed here.

1. One insurer reported that its corporate policy is to seek four-year agreements with hospitals; however, a number of Rhode Island hospitals are agreeing only to two-year contracts on the belief that the OHIC rate growth cap will not be long-lived. This certainly indicates the level of disaffection the hospitals have for the Hospital Contracting Standard. It also suggests that if OHIC were to eliminate this requirement, hospitals would press for higher reimbursement rates from the insurers than those permitted with the cap.
2. The large hospital systems and provider practices understand very well that the insurers must distribute a specified amount of financial support to them in the form of Primary Care Spend funds and quality funds. All insurers are concerned that this is creating an expectation, such that practices and hospitals know that even if they do not achieve their agreed upon goals, it is highly likely that they will still receive their quality and primary care spend payments. It is very difficult for the insurers to find other avenues to pay out the funds if goals are not met when reviewed at the end of the year. This observation is consistent with the insurer’s desire to have more flexibility in what will be recognized as Primary Care Spend. To mitigate this concern, OHIC should consider explicitly allowing insurers to make Primary Care Spend and quality improvement payments earnable and allow insures to count allocated, but unearned Primary Care Spend and quality improvement funds towards the insurer’s Primary Care Spend and quality improvement targets.
3. Two insurers, referencing OHIC’s hospital payment study which was possible because of the transparency provisions, expressed concern that OHIC’s ability to release hospital

rates is leading to a “race to the top,” rather than price competition. Their observation was that the transparency per se does not help patients make better selections because patients need to understand costs for episodes of care, not by specific services. These insurer representatives believe that transparency for transparency’s sake is not beneficial. In response to this concern, OHIC might consider supplementing the current requirement with one that requires insurers to develop web-based information that compares the cost of episodes of care across providers. OHIC could drive the process by identifying the episodes of care that should be priced out, criteria for developing the cost comparisons, and a timeframe for making the information available to the public. This type of cost comparison information is most useful when used in connection with plan designs with significant consumer financial responsibility.

### **Stakeholders’ Ideas for the Future of the Affordability Standards**

In general, all stakeholders recognized the significant, positive impact the Affordability Standards are having on the Rhode Island health care sector. The following is a listing of the ideas the providers, insurers and employers had about what direction the Affordability Standards should take in the future.

#### ***Primary Care Physicians***

Interviewed primary care physicians recognized the value of CSI and wanted to see the program enhanced and expanded to cover all primary care practices. In addition to requests for increased funding, practices suggested the following specific ideas as future foci for OHIC:

- Provide administrative support for practices seeking NCQA recognition. Specifically, the state should create a centralized resource to help all practices go through the application process.
- Enable better behavioral health integration by supporting provider development or acquisition of software that facilitates PCPs finding behavioral health providers, requesting an appointment and sharing clinical information.
- Continue to increase funding to primary care practices beyond 2014.
- Develop programs to support practices that have been successful at transformation and need to sustain change.
- Promote transparency of payment rates to providers and directly address the payment differentials by issuing regulations/guidelines that rationalize payment levels.

#### ***Employer***

The employer interviewed applauded the Affordability Standards, but did not think that they went far enough or that OHIC has the authority it needs to implement the changes that need to be made to rationalize health care delivery. The interviewee’s recommendations included:

- Obtain authority to set premiums.
- Promote ACOs that focus on coordination of care and break down existing silos of care.
- Develop a transition plan for an orderly transition in payment reform, which will likely result in hospital closings and other provider disruptions.
- Require transition payment models that move away from cost-based reimbursement and eliminate unprofitable programs.

- Recognize the fixed costs associated with unique services offered by academic institutions (e.g., recognize the value of services offered by academic institutions).
- Promote coordinated care by working with the Determination of Need program and the CurrentCare to move care from employers to individuals.

### *Hospitals*

Hospital representatives were consistent in their message that the Affordability Standards be updated to recognize the development of different types of payment models and new systems of care, such as the growth of ACOs. Accordingly, they believed that the Standards needed more flexibility and not focus primarily on hospital's unit pricing or on primary care. They want the Affordability Standards to support the development of systems of care that integrate care across providers.

### *Insurers*

Insurers also urged OHIC to build in flexibility within the regulations to allow different approaches and not inhibit payment reform innovation by being too prescriptive. The most concrete suggestion was to allow the primary care spend payments and the hospital incentive payments to be structured as incentives, rather than guaranteed payments. The insurers also expressed a need to be able to bring specialists under the medical home umbrella and to think about payments in terms of delivery systems and not solely primary care. Other recommendations included the following:

- Expand the focus of CSI to include support for preventive care (such as weight loss programs to combat obesity) even though cost savings will not be seen for years.
- Reduce the administrative burden on the insurers. If OHIC's desire is to have hospitals report data on coordination of care, for example, it should be through hospital licensing, and not through health insurer contracts.
- Link payments to outcome. For example, before requiring insurers to invest in CurrentCare or CSI, demonstrate that these initiatives have a positive impact on costs.
- Use the Affordability Standards to move the provider market to a point where providers can develop more sophisticated infrastructure to manage risk.
- Acknowledge that PCPs need support beyond the walls of the PCP. For example, PCPs need to gain information about specialists. One insurer would like the Affordability Standards to allow the cost of developing and distributing specialty data to PCPs to be recognized as primary care spend.

## **IV. Recommendations**

This evaluation, while not wholly conclusive, indicates that the Affordability Standards have constituted solid public policy that has produced benefit to Rhode Islanders. The standards should be extended through 2018 and evolve and improve to meet the changing marketplace in order to achieve OHIC's goals of making health insurance coverage affordable. In particular, it appears that the conditions are right for OHIC to modify the Affordability Standards to promote broader-based payment reform beyond hospital payment methodologies as accountable care organizations begin to develop in Rhode Island. Within this context, Bailit's recommendations are discussed as follows.

## Standard One: Expand Primary Care Spend

This standard, in conjunction with Standard Two to promote medical homes, has been very effective in galvanizing the Rhode Island market to bring about primary care transformation into medical homes. At the same time, to remain effective it must expand the type of primary care support that it permits to both support independent practices and recognize the growth of PCP aggregation and integration into larger provider organizations.

Bailit recommends continuing to require insurers to meet Primary Care Spend targets through 2018. To determine whether the current target needs adjusting, we recommend that OHIC update its original benchmarking study that was the basis for the current requirement to increase primary spend 1% annually. In 2012 primary care spending by Rhode Island insurers was approximately 9% of total medical expenses. This percentage exceeded many of the benchmarks used in 2009 to develop the current standard, the majority of which ranged between 7% and 8%. However, it is below the 10.9% target for 2014 and the 14% level of Group Health. Moreover, the providers Bailit interviewed consistently reported that they had more work to do to complete the transformation process and believed that they needed an increase in current funding to complete the process.

Based on an updated study, OHIC would determine if the spend targets can be increased.

Independent of whether the Primary Care Spend target is adjusted, Bailit recommends that OHIC continue to increase the percentage of funding that must be directed towards non-fee-for-service activities by 5% annually. To effectively direct the additional funding and recognize the changing marketplace, Bailit recommends including within the type of spending that meets the definition of non-fee-for-service primary care spending support for practice infrastructure and programs such as those that:

- Give risk-bearing provider groups the ability to effectively assume financial responsibility for managing the care for a defined population of patients, such as developing data informatics capabilities.
- Promote behavioral health – somatic health integration within the primary care practice, (e.g., funding to hire behavioral health specialists, funding the development of a universal care plan or funding the development of software that enables PCPs to locate and communicate with behavioral health providers about patient service needs.)
- Provide shared support that enables small, independent practices to become medical homes. Shared support could include care managers, pharmacists and data analysts.
- Promote the development and implementation of community-based care initiatives, such as evidence-based transitions of care programs developed through CMS' Community Based Advanced Care Management initiative.

Funding these types of infrastructure development and delivery redesign would continue to provide needed support to primary care practices, promote medical home transformation and recognize the growth of primary care aggregation and integration.

## Standard Two: Support Medical Home Transformation



Support of an all-insurer medical home initiative has been key to the transformation that has been occurring in Rhode Island. Bailit recommends that OHIC retain this Standard, but restructure it to quickly bring medical home transformation to scale such that significantly more than half of primary care practices are involved in medical home transformation. Bailit recommends that OHIC in partnership with PCPs and insurers consider three options:

- Accelerate the expansion of CSI and encourage or require insurers to grow their own program consist with CSI. This option retains the current program structure, but accelerates the rate of expansion of both CSI and the insurer-specific programs.
- End CSI when term of the current participation agreements is reached. Require the insurers to expand their own medical home initiatives. This approach acknowledges that CSI has served its function in priming the transformation pump and that insurers are in a position to move the initiative forward. The risk is that insurers will diverge from the CSI model. Having a consistent model has proved beneficial to both insurers and providers in promoting transformation.
- Transform CSI into an OHIC-insurer-provider partnership that serves a parameter defining function. In this role, CSI would define the specific requirements of any medical home initiative that the insurer's implement, but would not be a party to any contractual agreements. All contracting would be done by the insurers with the providers. This approach preserves the benefits of an all-insurer initiative, but frees OHIC from contractual responsibilities. At the same time, it allows insurers to move quickly to implement medical home transformation in a structured in a manner.

#### Standard Three: Support CurrentCare

Creating a viable Health Information Exchange creates the infrastructure for effective health care information sharing among providers, which is key to modernizing the provision of health care. Bailit recommends retaining this Standard in its current form. Until CurrentCare is fully operational, OHIC may want to designate a minimum funding level by insurers. Bailit further recommends that funding of CurrentCare not be recognized as meeting Primary Care Spend requirements, as it does not result in direct support for PCPs. If it is recognized by the Commissioner as an acceptable non-fee-for-service payment, limit the percentage of non-fee-for-service spending that may be directed to CurrentCare to avoid diminishing direct PCP support by insurers.

#### Standard Four: Payment Reform

With the emergence of provider aggregation and integration, Bailit believes that the time is appropriate to expand the scope of this standard to reach beyond hospital-based payment reform to include payment reform related to population-focused, risk-bearing entities. This expansion should provide a framework for the risk arrangements that are in negotiated between Rhode Island insurers and providers that promotes both quality improvement and reduced costs.

We recommend the OHIC modify this Standard as follows:

#### *Units of Service and Rates of Increase*

First, to eliminate the use of quality incentives as a way to circumvent the rate increase cap established by the CMS Index, enhance the current Units of Service and Rates of Increase requirement by adding a cap on rate increases to hospitals that includes the quality incentive.

Second, allow hospitals participating in population-based payment contracts with downside risk to be exempt from the hospital rate cap. Population-based contracts are designed to enable groups of providers to organize themselves to provide care in the most effective and efficient manner. With downside risk assumption, there are strong incentives to assure that each partner in the risk sharing arrangement is paid fairly and used in the most efficient manner. Therefore, it should be up to the risk-bearing entity to “divide up the pie” according to its needs. The recommendation below provides a safeguard by proposing rate increase caps on population-based payments made to the risk-bearing entities. This reinforces the mandate that these entities align internal incentives and not overpay any one type of provider.

These changes would retain controls on hospital rates for independent hospitals, and give risk-bearing entities that include hospitals flexibility on how to control costs within an entity-wide cap on increases.

### *Quality Initiative*

Insurers report that this Standard has captured the attention of hospitals and has helped to change the culture within Rhode Island hospitals to be more quality-focused. However, Bailit has identified several concerns.

First, as currently structured, the practice of including quality incentive payments as part of a rate increase is inflationary, since the quality dollars become part of the hospital’s base rate for the year to which subsequent rate increases apply. This practice undermines the goal of the Standard to slow the growth of hospital payments. To reduce the inflationary aspect of this practice, Bailit recommends that OHIC prohibit quality incentives from being included in the hospital’s base rates to which future rate increases apply.

Second, OHIC does not know if the quality incentives have been effective in improving quality of care. Bailit, therefore, recommends that the effectiveness of the quality incentive be assessed through the collection of data for measures from nationally-recognized measurement sets that target evidence-based activities that improve care and reduce costs. Bailit recommends OHIC work collaboratively with all insurers to determine the best approach to identifying measures, collecting and reporting data and developing other evaluation approaches, as appropriate.

### *Administrative Simplification*

The evaluation has revealed that administrative simplification initiatives may ultimately more effective when they address systemic issues that cross all insurers and providers. Bailit finds the current requirement to have been ineffective and recommends the OHIC eliminate the requirement. With the work of the OHIC Administrative Simplification Taskforce, this requirement is also duplicative of other, and arguably more effective, efforts.

### *Care Coordination*

This requirement currently requires insurers to require hospitals to take steps that are reported to a third party. Bailit recommends that OHIC eliminate this requirement because as constituted there is no direct means to confirm that it is resulting in desired improvement in care coordination. Instead, Bailit recommends that OHIC require that one of a hospital's quality measurement areas of focus be to measure the effectiveness of its transitions-of-care program(s). Measuring the effectiveness of the transition of care program would be included in a broader assessment of all the quality measures suggested elsewhere.

### *Transparency*

Insurers raised the concern that OHIC's disclosure of payment terms and levels of payment in its study of hospital rates has provided lower paid hospitals with information they will use to negotiate higher rates, rather than provide information that leads to cost reductions due to market competition. At the same time, OHIC may have valid and legitimate reasons for publicly releasing this information. Therefore, Bailit recommends that OHIC retain this requirement to assure it have the flexibility to pursue its policy goals.

In direct response to the insurers' concerns that transparency leads to the race to the top and not price competition, OHIC may consider supplementing the current requirement with one that requires insurers to develop web-based information that compares the cost of episodes of care across providers. OHIC could drive the process by identifying the episodes of care that should be priced out, criteria for developing the cost comparisons, and a timeframe for making the information available to the public.

### *New Payment Reform Standard*

With the development of provider entities interested in participating in population-based payment arrangements, Bailit recommends that Standard Four's original purpose of promoting payment reform now be more directly pursued. Bailit recommends that the standard be restructured to recognize the new role of accountable care organizations in Rhode Island's health care ecosystem, while retaining several existing requirements discussed above. The recommendations also reflect the experience elsewhere that significant transformational change does not occur until the provider entities accept downside risk.

Specifically, to promote payment reform, Bailit recommends that OHIC require the following of insurers:

- A specified percentage of covered lives should be covered under contracts with providers who are assuming population-based responsibilities of caring for a defined group of enrollees. The percentages of covered lives covered by population-based contracts should increase each year. One possible graduation would be: Year One - 25%; Year Two - 50% and Year Three - 75%.
- A specified percentage of covered lives should be covered under population-based contracts with providers who are assuming downside risk. The percentages of covered lives covered under contracts with downside risk should increase each year. One possible graduation would be: Year One - 0%; Year Two - 15% and Year Three - 30%.
- Limit annual growth in global payment amounts to an externally-calculated economic index, such as the All Urban Consumers Less Food and Energy Consumer Price Index (CPI), the Rhode Island Gross Domestic Product or the CMS National Prospective Payment System Hospital Input Price Index.

- Require payment to include a quality component, such that payments are contingent on achieving specified quality goals.

### *Cross-Standard Recommendations*

Insurers consistently expressed the concern that providers viewed the Primary Care Spend funding and the quality incentives as guaranteed and wanted flexibility to clearly make the funding contingent up meeting agreed-upon criteria. They expressed the concern that if they ended up not paying out all the allocated funding, they would not meet their obligations under the Affordability Standards. Bailit finds merit in the insurers' arguments and recommends that OHIC allow insurers to count allocated, but unearned Primary Care Spend and quality funds towards the insurer's Affordability Standard obligations, so long as the insurers distribute all unearned funds among providers that did meet the payout requirements. This approach will provide continuing incentives for providers to meet their targets while enabling insurers to meet their regulatory requirements.

OHIC has expressed concern that as a small state agency it does not have a large staff to monitor implementation of the Affordability Standards. In response to that concern, Bailit recommends asking insurers to report specified outcome data and use the results to target areas requiring increase scrutiny. In addition to what is currently being reported to OHIC, the insurers would under these recommendations report the following outcome measures that OHIC could use to evaluate insurer compliance:

- percentage of total payments paid under population-based payment methodologies;
- ROI analyses of at least two of the quality initiatives, in addition to an ROI analysis of the care coordination (transitions of care) initiative;
- weighted average annual increase in hospital payments, and
- weighted average annual increase in population-based payments.

### *No Guarantees*

Insurers raised the concern that the quality requirement for hospitals and the 1% Primary Care Spend Standard for PCPs are increasingly viewed by providers as guaranteed payments, rather than funds to be earned. If this perspective takes hold, the momentum towards positive change will be diminished. To mitigate the development of a feeling that these are guaranteed payments, Bailit recommends that OHIC explicitly allow insurers to make Primary Care Spend payments and the 2% of revenue quality funds conditional on performance. The quality payments would be conditional on providers meeting negotiated goals and the Primary Care Spend funds would be conditional on providers meeting specific program goals (e.g., achieving NCQA recognition by a certain date or hiring a care manager by a certain date.) OHIC would also need to allow insurers to count allocated, but unearned Primary Care Spend and quality funds towards the insurer's Primary Care Spend target and 2% of revenue target. OHIC should, however, require insurers to distribute all unearned funds among providers that did meet the requirement(s).

### *Self-Insured Accounts*

The three largest Rhode Island Insurers reported that self-insured accounts support the Affordability Standards only to the extent that they include self-insured covered lives when determining CSI PMPM payments to participating providers. Currently, only United is in the

process of amending its self-insured contracts to cover costs, including PMPM payments and incentive payments that fall outside of fee schedules. To address this “free loader” issue, Bailit recommends that OHIC, as part of the rate review process, obtain information as to whether insured premiums are inappropriately funding the Affordability Standards. Two pieces of information that would appear to be particularly germane are:

- whether the insurer has developed and implemented billing codes with self-insured accounts for PCMH functions such as care management, and
- whether insurers have amended self-insured account agreements to include funding the costs of those Affordability Standards from which the employers should benefit.

OHIC could then share the results of the data collection with insurers who are not spreading Affordability Standard costs to self-insured accounts and use its position to urge including self-insured accounts.

## **Conclusion**

The OHIC Affordability Standards represent good governance. The Standards have helped galvanize transformation of primary care in Rhode Island and have been instrumental in focusing hospitals on improving quality of care. There is still more transformation to take place in Rhode Island. The Affordability Standards continue to have an important role to play in shaping and moving transformation forward. With the marketplace changing, the Affordability Standards should be modified to recognize the need to spread transformation into smaller unaffiliated practices and to support the development of integrated care models and risk-based provider contracts.