

## The Affordability Standards: A Summary

### Introduction

In 2009, at the advice of its Health Insurance Advisory Council, the State of Rhode Island Office of the Health Insurance Commissioner (OHIC) directed commercial health insurance issuers with significant market shares in the state to comply with a set of four criteria, collectively termed the Affordability Standards, aimed at improving the affordability of health care in Rhode Island. Specifically, the Affordability Standards require issuers to:

1. Expand and improve primary care infrastructure
2. Spread the adoption of the patient-centered medical home
3. Support CurrentCare, the state's health information exchange
4. Work toward comprehensive payment reform across the delivery system

The Affordability Standards went into effect in 2010.

### Primary Care Spend Standard

The first standard represents a core component of OHIC's strategy to facilitate delivery system reform in Rhode Island by bolstering the state's primary care infrastructure and promoting more efficient, affordable health care. It requires issuers to 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. Issuers are not allowed to turn this new spending into higher premiums. OHIC also sets the percentage of primary care spending that must be paid through means other than fee for service rate increases.

### Patient-Centered Medical Home Standard

The second standard requires issuers to provide financial support for the Rhode Island Chronic Care Sustainability Initiative (RI-CSI), a nationally recognized all-payer patient-centered medical home pilot project, established by OHIC. The Rhode Island Foundation has been, and will continue to be, the sole fiscal agent for RI-CSI, serving as the administrative and fiscal home for this project since its inception.

### CurrentCare Standard

The third standard requires issuers to provide financial support for CurrentCare, Rhode Island's health information exchange (not to be confused with the Rhode Island Health Benefits Exchange). CurrentCare 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 represents a statewide

health information technology investment with significant potential to contribute to reducing medical expense trend while making a positive impact on health outcomes.

### **Hospital Contracting Conditions Standard**

To support standard four, OHIC has put into place six conditions for issuer contracts with hospitals in Rhode Island to be implemented by issuers upon contract execution, renewal, or extension. The current form of each condition is as follows:

- 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. Nothing in this requirement prevents contract terms that provide additional or stronger payment incentives toward quality and efficiency such as performance bonuses, bundled payments, global payments or the formation of supporting functions such as Accountable Care Organizations.
- 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 Centers for Medicare and Medicaid Services (CMS) National Prospective Payment System Hospital Input Price Index (“Index”), for all contractual and optional years covered by the contract. The Index applicable to the new contract year will be based on the most recent Hospital 4 Quarter Moving Average Percent Change published and available as of the signing of the contract. For renewal and optional years it will be based on the applicable most recent Index 4 Quarter Moving Average Percent Change period available prior to the new contract year. Upon written request of an issuer, supported by the hospital's written agreement with the issuer's request, the Commissioner may approve exceptions to the Index limit for those hospital contracts which the issuer demonstrates, to the Commissioner's satisfaction, align significant financial responsibility for the total costs of care for a defined population and set of services in manners generally consistent with the alternative Medicare payment mechanisms proposed under the Affordable Care Act. Issuers are encouraged to file such requests.
- 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. An issuer's quality incentive program may also include one or more of the following: (1) other nationally accepted clinical quality, service quality, or efficiency-based measures; (2) mutually agreed upon metrics of clinical quality that may have no clear precedent nationally, and (3) mutually agreed upon clinical quality improvement activities that support new models of care coordination. The measures, performance levels, payment levels, and payment mechanisms must be articulated in the contract. A issuer may make

interim payments in the event that interim measures of performance have been met; provided that the interim payments must be commensurate with the achievement of the interim measures; and provided further that a final settlement may only occur after the measurement period; and provided further that if the annual measures of performance have not been achieved, the hospital shall be required to remit interim payments back to the issuer.

- 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. On or before January 1, 2013 [issuer name] shall file with OHIC, in a format approved by the Commissioner, a report identifying and describing for each hospital or hospital system contract subject to these conditions, the specific and substantive programs or initiatives designed to achieve greater administrative efficiencies, the benchmarks used to measure progress, the progress achieved by the issuer and the hospital or hospital system during the previous calendar year with respect to each program or initiative, and the planned activities of the issuer and the hospital or hospital system during the succeeding calendar year. The report shall include a demonstration that the hospital or hospital system has had an opportunity to participate in and review the report, and shall include any comments of the hospital or hospital system concerning the report. In the event a contract with a hospital or hospital system is not executed before October 1, 2012, [issuer name] shall have 90 days from the date the contract is signed to submit a report in accordance with this condition with respect to such contract.
- 5. 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 the following nine best practices that have been documented to lead to improved quality of inpatient discharges and transitions of care: (1) notify primary care physician (PCP) about hospital utilization, (2) provide receiving clinicians with hospital clinician's contact information upon discharge, (3) provide patient with effective education prior to discharge, (4) provide patient with written discharge instructions prior to discharge, (5) provide patient with follow-up phone number prior to discharge, (6) perform medication reconciliation prior to discharge, (7) schedule patient outpatient follow-up appointment prior to discharge, (8) provide PCP with summary clinical information at discharge, and (9) invite PCP to participate in end-of-life discussions during hospital visit.
- 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. Any contractual language forbidding the disclosure of contractual or payment information shall have: (1) a specific exemption for payment information shared to or by providers in shared risk arrangements similar to those described in condition number one, above, who

seek such information for the purposes of improved care coordination, or support for innovative provider payment arrangements and (2) an affirmative obligation of the issuer to provide such payment information to those providers when requested.

These conditions may be revised on an annual basis at the discretion of OHIC.

**For More Information**

For more information, please visit [www.ohic.ri.gov](http://www.ohic.ri.gov).